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ABSTRACT

A project evaluated 23 preregistration midwifery education programs in Britain. Phase 1 reviewed the programs and identified a cohort of students for indepth study. Phase 2 followed this cohort into their first year in practice. A survey selected six case study sites. Findings showed a common cause of attrition was students being unable to balance program demands with family commitments and expectations. Personal qualities played a particularly vital role in determining competence for midwifery practice. All programs demonstrated good evidence of a variety of teaching and assessment methods, a student-centered approach to learning, and an emphasis on lifelong learning. Students with no learning experience as a midwife before the program ended felt less able to cope with the transition to midwife. A model of competence was developed that incorporated three essential interlinked dimensions of competence: professional/friend approach, individualized approach, and clinical competence. The midwives were well prepared to provide holistic midwifery care. Support for new midwives was needed on most delivery wards. By the end of the first year in practice, managers and supervisors described most midwives as competent, confident, and quick learners. Examples of good practice in assessment included written procedures and guidelines for assessors and clear assessment documents. An assessment matrix was produced. (Appendixes include methodology, Midwives Directives, conference papers, and 135 references.) (YLB)

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AN OUTCOME EVALUATION OF THE EFFECTIVENESS OF PRE-REGISTRATION MIDWIFERY PROGRAMMES OF EDUCATION

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AN OUTCOME EVALUATION OF THE EFFECTIVENESS OF PRE-REGISTRATION MIDWIFERY PROGRAMMES OF EDUCATION

PREFACE

The English National Board is delighted to publish this important report which evaluated the effectiveness of the outcomes of pre-registration midwifery education programmes. The Board welcomes the opportunity to disseminate the findings to policy makers, managers, practitioners, educationalists and researchers within education and the health service.

The findings of this report will make a significant addition to the cumulative body of knowledge in research into professional education and the contribution which education makes to practice. The conclusions of the report should help professional and academic staff to apply evidence-based findings to plan and develop educational programmes and the related assessment strategies which are crucial to the integration of theory and practice.

The report will be of particular significance to institutions offering pre-registration midwifery programmes, but will be of relevance to multi professional groups who are concerned with the relationship between academic and professional education and practice. Supervisors of Midwives, and managers will find the assessment matrix developed through the research to be of particular relevance.

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Terminology

Approved Midwife Teacher	Normally the senior midwifery education manager within the institution and who is accountable to the ENB for all aspects of midwifery education
Assessor(s)	The appropriately qualified and experienced midwives who are required to facilitate student learning, supervise practice and assess the students' level of attainment related to the stated outcomes of the programme
"EME" Project	Acronym referring to key words in the Project's brief, "Effectiveness of Midwifery Education". The Project's title in full is "An outcome Evaluation of Pre-Registration Midwifery Programmes of Education"
ENB	English National Board for Nursing, Midwifery and Health Visiting
ENB 10 Key Characteristics	These were designed following a research study concerned with analysing the training needs of nurses, midwives and health visitors (ENB, 1991). The key characteristics represent the key areas of knowledge, skills and expertise which all UKCC practitioners should have. They form part of the ENB Framework and Higher Award which provides a systematic way for practitioners to identify their professional development needs.
Mentor	"An individual who has an understanding of the context of the student's learning experience and is selected by the student for the purposes of providing guidance and support" (ENB 1996, 6.5). (Note: This term is frequently used by those interviewed

	when the term 'assessor' would have been more appropriate.)
PMAN	The ENB's Professional Midwifery Advisory Network comprising invited representatives from midwifery education, clinical practice, midwifery research, management and supervisors of midwives. They are responsible for contributing to the achievement of the ENB's objectives relating to midwifery education, practice and supervision through the Director of Midwifery Education and Practice
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

The female gender is used throughout as all interviewees were women.

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EXECUTIVE SUMMARY

Introduction

Midwifery education, along with other types of professional education and training, has had its own unique share of changes. One such change was the introduction in 1989 by the ENB of three-year diploma/degree pre-registration programmes of midwifery education. Chapter One of the report sets out the background to this development.

The ENB has now validated over 40 of these three and four-year programmes, which run alongside the shortened programmes for registered nurses who wish to become midwives. The purpose of this ENB commissioned project was primarily to evaluate the effectiveness of the new three-year diploma and degree pre-registration programmes of midwifery education in terms of their outcomes. To do this the work of the project was split into two phases.

Anticipated project outcomes included: a review of programme curricula (Chapter 2); development of a model of midwifery competence (Chapter 3); exploration of attrition (Chapter 4); evaluation of actual outcomes of programmes (Chapters 4-7); evaluation of current assessment strategies (Chapter 11); guidelines for effective assessment and assessment matrix (Chapter 10); guidelines for effective assessor preparation (Chapter 11); examination of support and learning needs of students following registration (Chapter 8); exploration of career patterns and retention rates (Chapter 8); and difficulties associated with failing students (Chapter 9).

Project Aims and Design (Chapter One)

The project's central aim was to be achieved through a review of existing three-year pre-registration programmes of midwifery education and a study of a cohort of midwives, qualified following completion of a pre-registration programme, into their first year in practice. Thirty-nine students were chosen from the 6 case study institutions which were selected using specific selection criteria (Appendix 1). The choice of students was managed in such a way as to produce a sample which was reasonably representative of the programmes and the whole student cohort. Interviews were conducted with the students and also with teachers, and midwives working with them as assessors, team members, managers and supervisors of midwives. Appendices provide details of analysis strategies applied to interview data (Appendix 2) and the project's ethical guidelines (Appendix 3).

The project's methodology included a national survey, multi-site case studies, and a variety of other methods of data collection, which were incorporated to address specific issues requiring further investigation (Figure 1.1).

The ways in which the specific aims of the project have been addressed are summarised as follows:

(1) an examination of the philosophy, theoretical framework, design and content of curricula

Chapter 2 presents an in-depth analysis of curriculum documents from 23 pre-registration programmes out of a possible 30. This analysis reveals a great deal of commonality in relation to current approaches to midwifery practice and the changing role of the midwife. However whilst all programmes contend that theory and practice should be integrated, the compartmentalised arrangement of subject disciplines and the course structure generally would appear to favour a Technical Rationality model (Schön 1983).

All programmes demonstrated good evidence of a student-centred approach to learning, a variety of teaching methods, similar content and an emphasis on lifelong learning and research. Assessment strategies however were very different, although many attempted to base their schemes around the UKCC learning outcomes (Rule 33 3c). Evidence of dialogue between student and assessor(s) was lacking in relation to assessment documentation although the role of intuition and qualitative thinking appeared to be valued in course submissions rather than the task based framework which was sometimes provided. Assessment schemes showed a tendency to fragment competence into small and separate parts rather than a unified whole.

(2) the identification and development, as required, of new tools for the assessment of the outcomes of midwifery programmes of education

A conceptual model of the competence required of a midwife at the point of registration against which assessment strategies could be evaluated was developed and Chapter 3 gives details of the process followed by the team to do this. A review of the literature on competence in education, industry, midwifery and nursing was undertaken (Worth-Butler, Murphy and Fraser 1994, 1995) and this was followed by a major conference of key stakeholders. Two contentious issues emerged: the interrelationship of competence, performance and capability; and the validity of competence over time. It was concluded that there is no commonly shared definition of a competent midwife at the point of registration and that it was necessary to use a wide variety of sources in order to inform such a model (page 59). Three closely interlinked dimensions were identified to form the focus for midwifery competence (page 62):

- the ability to be autonomous and professional but "with woman" **(professional/friend approach)**
- the ability to provide individualised care **(individualised approach)**
- a sound knowledge base and appropriate skills for the provision of midwifery care **(clinical competence)**.

One or more dimensions may be more prominent in any given situation or at any particular time, reflecting the role of context in professional competence and the underpinning affective processes that enable a competent individual to cope with differences from situation to situation.

In Chapter 10, an assessment matrix for pre-registration midwifery education programmes is developed. In relation to this we found that there was significant variation in how institutions linked the statutory requirements for the role of the midwife to their assessment strategies, one basing its assessment around the Activities of a Midwife (EC 1980) and others using Rule 33 (3c) (i) to (xi) of the UKCC Midwives Rules (1993) but generally omitting parts 2 and 3c. Some assessment strategies appeared to be much less comprehensive than others. Wide consultation about this led to the development of an assessment matrix which is proposed as a framework for future practice. Questionnaires were circulated to the ENB's Professional Midwifery Advisory Network (PMAN). PMAN members then participated in small group discussions to help clarify important assessment issues. These discussions were also supplemented by focus groups in 6 of the case study sites with participants from all areas of the midwifery profession. Following deliberations on a suitable framework for the matrix, a model of a competent midwife was developed and tested. The basis for developing an assessment matrix was that it should be realistic in terms of student capability at the point of registration, and should be based on research evidence, be comprehensive, clear and unambiguous, demonstrate the integration of theory and practice, and the standard required for contemporary midwifery practice in a Changing Childbirth (DoH 1993) context. The main use of the assessment matrix was as an effective framework against which to judge individual schemes of assessment.

This matrix has the potential to provide midwives, who are now being expected to change their work patterns to meet the recommendations in Changing Childbirth, with a relevant base upon which to build an assessment of their areas of particular expertise and deficits. In conjunction with the 10 Key Characteristics of the ENB Framework and Higher Award (ENB 1991), the matrix could be useful in the development of an action plan for midwives required to practise in less familiar contexts.

(3) An assessment of the intended and actual outcomes of midwifery programmes of education in terms of knowledge, attitudes, competencies and skills

Intended outcomes outlined in course documents were compared with actual outcomes evidenced in the data obtained (Chapter 4 gives details of this). These have been analysed in relation to the three dimensions contained within our model of competence.

Part of this assessment involved gathering information about student attrition rates. These revealed that attrition was highest in the first year and lowest in the third year. Reasons for students leaving were explored, as were the consequences. This also led to a consideration of the difficulties encountered in recruitment and selection of candidates for the programme, particularly in confronting applicants with the demands it would make upon them.

Chapter 5 explores how intended outcomes of three-year pre-registration programmes of midwifery education appear to have been met in terms of preparing midwives to fulfil the professional/friend approach dimension of our model of competence. This evaluation was based on data on student ability at the point of registration and in the year following from assessors, more experienced midwives, managers and supervisors of midwives. Midwives appeared to have developed as effective team members during their first year in practice and were noted as reflective and analytical practitioners who were motivated towards lifelong learning. Many were developing confidence and assertiveness as communicators. Problems in fulfilling the professional/friend approach usually centred around a lack of confidence and problems with making the transition from student to accountable and responsible practitioner. Possible ways of improving programmes to deal with this included: increasing levels of responsibility for senior students near the end of their programme; involving students in decision making; helping students who had been identified as lacking in confidence to become more confident; and better preparation of assessors to know what to expect of students. Students should be allowed "to be a midwife" before the end of the programme to assist with the transition from student to accountable and responsible practitioner.

Chapter 6 explores how programmes prepared students to fulfil the individualised approach dimension of competence. Interview data portrayed the ability of study midwives, at registration and during their first year as practitioners, very positively. Evidence showed that study midwives were very committed to a philosophy of woman-centred care which focused on a needs meeting, problem solving approach. Care given on this basis was to a very high standard and feedback was positive. Study midwives felt very well prepared with an understanding of the factors influencing individual needs and colleagues supported their ability to use this theory in day to day practice. Study midwives appeared to be orientated towards a system of care that involved assessing, planning, implementing and evaluating care, though some had limited experience in planning and evaluating care. Study midwives also saw themselves as holistic practitioners and were anxious to develop a full range of skills which they felt were necessary to fulfil this. They also found that they were required to provide care for much larger groups of women after they registered, and needed to develop in terms of prioritising and managing time; they sometimes experienced stress in trying to meet individual needs whilst ensuring equity of care for other women in their care.

Chapter 7 explores how students were able to fulfil the intended outcomes which relate to the clinical competence dimension, focusing mainly on knowledge and skills, and being able to apply them appropriately to each practice situation. Interviewees agreed that study midwives, who had all the basic skills for normal midwifery practice and a good knowledge base, were safe at registration as long as they fulfilled 3 conditions:

(1) they were aware of their own limitations and were prepared to ask for help;

(2) they were able to detect deviations from normal and refer these deviations to a more experienced practitioner;

(3) and that their practice was research based.

Interviewees also stated that midwives at registration should be confident but not over-confident and most problems that students had at registration in this regard were resolved by the end of the first 6 months in practice.

It was felt that study midwives had a comprehensive knowledge base but gaps were noted in terms of some aspects of drug administration and knowledge of medical conditions. While study midwives were seen as having the essential skills they required, they needed a period of consolidation following registration. In a few cases, particular gaps were noted in terms of catheterisation, episiotomy, administering drugs and confidently interpreting vaginal examinations. Study midwives were shown to be very capable of providing care in normal pregnancy but needed considerable support when caring for women who were ill, had pre-existing medical conditions or developed complications. Areas where study midwives developed most following registration included ward management skills, counselling skills and teaching skills. Time management, prioritising and advocacy skills could only be fully developed following registration.

The issue of borderline students is considered (Chapter 9), along with the problems involved in failing students. Illustrative case studies are presented of 3 students who all qualified, despite reservations being raised about them either during their course, or in one case, during the first year in practice. Where there is insufficient assessment evidence, the 'benefit of the doubt' is often given in the student's favour, and teachers are not always made aware of problems in relation to students in practice placements. Assessors may not be willing to refer or fail a student if they have been inadequately prepared, lack confidence in making their own judgements or do not know the student very well. Assessment documents may also fail to test evidence of capability across a variety of contexts, and it may be possible for students to manipulate assessors or the system in order to pass. Where good communication between teachers and assessors was evident, difficulties in making assessment decisions were reduced.

(4) An evaluation of the effectiveness of pre-registration midwifery programmes of education in terms of knowledge, attitudes, competencies and skills, one year on

The first year in practice is the subject of Chapter 8. We were able to follow 38 out of the original 39 midwives through to the end of the first year in practice, and all achieved some form of employment on registration. Data for this phase of the project was collected through interviews with case study midwives (after six months and after one year in practice) and also with midwife colleagues and supervisors of midwives or midwifery managers.

Over half the study midwives felt they had adequate or good support initially at registration, having been given an induction programme or a preceptor to work with, or having received good support from team leaders, managers and team midwives and colleagues. The need to 'double check' decisions soon tailed off as confidence increased. In addition, they found the support provided by supervisors of midwives and managers facilitated reflection on practice and enabled them to identify and meet their learning needs.

Some new midwives would have liked more support following registration, particularly in coping with the sudden change from student to accountable and responsible practitioner. As with shortened programme midwives, it appeared that most support was needed on delivery suite especially when dealing with complicated cases.

Chapter 11 deals with the issue of programme effectiveness and draws together the main issues covered in previous chapters. It discusses whether expectations of midwives qualifying from three-year pre-registration programmes are realistic, and that it may have been possible to provide more effective learning opportunities. Students should be allowed "to be a midwife" before qualifying in order to prepare them for their role after qualifying. The difficulty experienced by some institutions in meeting the requirements of two validating bodies, the ENB and the institution of higher education is also highlighted. This becomes apparent through a consideration of assessment issues such as the role of examinations, assessor preparation, teacher involvement in assessment, reliability of assessors, and documents that facilitate the recording of evidence.

(5) The identification of continuing educational needs of midwives qualified via the three-year pre-registration route since 1992

Chapters 5 to 7 consider the actual outcomes of programmes in the context of the team's three-dimensional model, and identify areas where the study midwives needed to develop during their first year in practice. The main areas were to consolidate their good knowledge base by gaining experience and confidence; and to develop communication skills with colleagues, mothers and families and learn to cope with accountability and decision-making. Study midwives appeared able to identify their own needs for development and were willing to acknowledge their limitations. Four study midwives had particular difficulty in managing their time and prioritising their work and needed support in gaining experience of this. With regard to clinical competence, some needed to consolidate their skills and were purposely allocated to delivery suites to gain confidence there before moving on. Many wished to learn the skills needed to care for women with complications, such as putting up blood, caring for central venous pressure (CVP) lines and dealing with intra-venous infusion. Some needed to become proficient at performing episiotomies, learning to suture, interpreting cardio-tocograph tracings (CTG), and others needed to gain experience of artificial rupture of membranes (ARM), catheterisation and infant resuscitation, although they did have the background knowledge. Missing skills were included in standard induction or in-service training programmes for some new midwives and these included suturing, topping-up epidurals, IV cannulation, giving IV drugs, prostin induction, scrubbing for theatre and skills for the neonatal unit. Study midwives also identified experiences which they had not been able to gain while students such as twin and breech delivery, and which they hoped to cover after qualification.

Students, assessors and midwives also felt students, whilst safe, were lacking in experience in administering drugs, knowledge of drug side effects and drug interactions.

(6) Identification of the retention rates, career patterns and career intentions of midwives qualified via the three-year pre-registration route since 1992

Career patterns of study midwives are covered in Chapter 8, and Table 8.1 (page 148) shows that all but two of the case study midwives were employed within NHS Trusts, 34 having permanent or temporary contracts at registration, and 3 being given contracts after a few months as agency or bank midwives. By the end of the first year, 37 were still working in midwifery, one had given up midwifery for personal reasons and the other had taken up employment in a field where midwifery knowledge was useful, and was planning to do bank work in order to keep her midwifery skills up to date. Most were working in hospital positions, even though the majority wished to work in community-based teams or group practices in the future. Table 8.2 covers the midwives' career intentions at the end of their first year in practice, and Appendix 7 gives more detail of the individual career patterns of the study midwives in our sample. Overall study midwives were very committed to woman-centred midwifery care but some expressed disillusionment that practices are still a long way from the ideals set out in the *Changing Childbirth* report (DoH 1993).

INTRODUCTION TO THE PROJECT

There have been major changes in all types of professional education and training in recent years, and midwifery education has had its own unique share of such changes. Of major relevance to this project was the introduction by the English National Board for Nursing, Midwifery and Health Visiting (ENB) in 1989, of three-year diploma/degree pre-registration programmes of midwifery education. This was in response to a Department of Health and Social Security/ENB commissioned study of "direct entry" midwifery (Radford and Thompson 1988).

Prior to this, only one institution had regularly offered a direct entry route into midwifery. This institution's programme was not validated by a higher education institution although it attracted a large number of high calibre applicants. In response to a request from the ENB, the Department of Health agreed to provide pump-priming for new ENB/Higher Education conjointly validated pre-registration midwifery programmes of education. The initial target was for one programme in each Regional Health Authority to meet the demand for more direct entry routes into midwifery. These were to be provided alongside the already well established post-registration courses (now called pre-registration programmes, shortened) for those wishing to become midwives after already becoming registered as nurses (Part 1 or Part 12 of the UKCC professional register). However since the initial pump-priming monies, there has been an overwhelming demand for the three-year programmes and the ENB has now validated over 40 of these programmes. This ENB commissioned evaluation was carried out with the prime aim of evaluating the effectiveness of these new three-year diploma and degree pre-registration programmes of midwifery education.

CHAPTER ONE

PROJECT AIMS AND DESIGN

1.1 Background

Prior to the first Midwives' Act of 1902, there was no requirement for women who practised as midwives to be registered or to have undertaken any programme of instruction. Subsequently, women were only legally permitted to practise as midwives if they held a certificate issued by one of the institutions approved to offer midwifery training and were entered on the Midwives Roll of the Central Midwives' Board. Until 1916, very few women came into midwifery via nursing and there was only one route of preparation (Radford and Thompson, 1988). From the 1920s onwards there was an increase in nurses changing professions and training to become midwives. By the mid-1980s only one training school remained for non-nurse student midwives, most midwives having followed a shortened programme for registered nurses. Concerns about adequate recruitment and retention of midwives and the need to provide midwives who will undertake their full role and responsibilities led the ENB to urge the Department of Health and Social Security to fund a three-year study into Direct Entry Training (Radford and Thompson, 1988). As a consequence of the report it was agreed that each Health Region in England should develop at least one diploma or degree level Direct Entry Course, now called the Pre-Registration Midwifery Programme of Education. In 1989 the Department of Health provided pump-priming monies for fourteen sites to develop these programmes and in September 1990 the first pilot programmes enrolled their students.

At the same time as these three-year pre-registration midwifery programmes were being designed and implemented, small schools of midwifery were amalgamating and becoming part of large colleges of nursing and midwifery. Now that the programmes required academic as well as professional validation, the colleges had to link with or merge into their local university, polytechnic (now new university) or institute of higher education. Curriculum designers had therefore to ensure that the intended curriculum met the requirements for their academic institution's award and also the requirements for admission to Part 10 of the United Kingdom Central Council (UKCC) Professional Register for Nurses, Midwives and Health Visitors. Given all of these changes it is perhaps surprising that many other institutions set up pre-registration programmes without the benefit of pump-priming. The intention of the Department of Health had been to evaluate the fourteen programmes developed in the first two years, in terms of the work force implications and the learning process, before promoting their further expansion. The Department commissioned a three-year study for this purpose in 1990 but by the time the report was presented, thirty-five pre-registration programmes had been validated (Kent et al 1994). It was against this background that the ENB commissioned an outcome evaluation project, known now as the EME (Effectiveness of Midwifery Education) evaluation project.

1.2 Project Aims

The overall aim of this project was to evaluate the effectiveness of pre-registration midwifery programmes of education in terms of their outcomes. This was to be achieved through:

(a) **a review of existing three-year pre-registration programmes of midwifery education**

At the time the project commenced, thirty institutions across England were offering three-year programmes of pre-registration midwifery education[1]. The Approved Midwife Teachers from all thirty institutions were written to and asked to provide details necessary to select six case study institutions including curriculum and assessment documents, and invited to participate. Twenty-three institutions provided or made available course documents to be used in an analysis of curricula. Using specific selection criteria (Appendix 1) the six institutions were selected by the project team for inclusion and agreed to participate.

(b) a study of a cohort of midwives, qualified following completion of a pre-registration programme, into their first year in practice

Once access was gained to the case study sites, thirty-nine students were chosen to provide a specific forum for our evaluation within these six institutions. These students were selected by a process which invited all students to consider the implications of becoming involved in our project. It was therefore partly an opportunity sample but it was also chosen so as to be reasonably representative of the courses and the whole student cohort. All of the chosen students took part in interviews and gave permission for the team to obtain data about them from midwives working with them as assessors, team members, managers and supervisors of midwives. We were also allowed to gain access to the college files and assessment records. More details about the sample are given later in this chapter.

The original ENB specification proposed that the evaluation should be carried out through two phases, as follows:

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[1] A minority of institutions had approval for a four-year degree programme but these were not included

Phase 1

Phase 1 of the project involved participants as students, their teachers and assessors and focused mainly on the assessment of competence and student ability to fulfil the role of the midwife at the point of registration. It involved:

(a) An examination of the philosophy, theoretical framework, design and content of curricula

This involved an analysis of curriculum and assessment documents used by institutions providing three-year pre-registration midwifery education programmes and the results of this analysis are reported in Chapter 2. This exercise was one important aspect of the ground work carried out in phase 1 to set the scene for the study and to explore anticipated programme outcomes in terms of a model for effective midwifery practice.

(b) The identification and development, as required, of new tools for the assessment of the outcomes of midwifery programmes of education

Phase 1 of the project also involved an evaluation of current assessment practices on three-year pre-registration midwifery education programmes and the identification of good practices and areas for further development. The first steps, in this area, involved the development of a framework - a conceptual model of the competence required of a midwife at the point of registration against which assessment strategies could be evaluated. This is covered in more detail in Chapter 3. Using the areas of good practice identified and issues raised in the course of the study, the project team has developed and tested an assessment matrix. This matrix should be of use to institutions when developing their assessment strategies.

(c) **An assessment of the intended and actual outcomes of midwifery programmes of education in terms of knowledge, attitudes, competencies and skills**

Intended outcomes, as outlined in course documents, were compared with actual outcomes evidenced in the data from student, teacher and assessor interviews and from student assessment records and examples of course work. In addition, interview data from study midwives and the midwife colleagues in phase 2 gave a retrospective picture of student ability at the point of registration. Student ability at the point of registration is covered in more detail in Chapters 5, 6 and 7.

Phase 2

Phase 2 of the project involved following up study participants as midwives in their first year as practitioners. This phase focused on three areas:

(a) **An evaluation of the effectiveness of pre-registration midwifery programmes of education in terms of knowledge, attitudes, competencies and skills, one year on**

(b) **The identification of continuing educational needs of midwives qualified via the three year pre-registration route since 1992**

(c) **Identification of the retention rates, career patterns and career intentions of midwives qualified via the three year pre-registration route since 1992**

One of the benefits of a three-year long study was that we were able to follow our cohort of midwives identified through the six case study institutions, through their first year in professional practice. This allowed us not only to evaluate their continuing educational needs and the provision that was made for them, but also allowed us to gather further data about their competence, developed during their pre-registration programmes, and now being put to use in professional practice. This further study of the thirty-nine students identified in phase 1 involved two more interviews with each student, after four to six months and one year, along with in each case a midwife who had worked closely with them during the year, and their supervisor of midwives or manager. These interviews focused on the development of midwives as practitioners during their first year in practice along with their further developmental and educational needs in terms of experience, skill and knowledge. Data on career patterns and intentions along with retention rates was also collected, and this will be presented in a later chapter.

1.3 Project Methodology

Cronbach (1982) described the design of educational evaluation investigations as an art. He also argued that each evaluation needs to be designed in relation to the context within which it is to take place, and in such a way as "to produce maximally useful evidence within a specified budget". The current evaluation took place within a very specific context and its design occurred in relation both to the specific context of pre-registration midwifery education, and that of an ENB commissioned study with a defined budget, timescale, and set of objectives. Furthermore the contract for the evaluation was acquired through a process of competitive tendering within which an evaluation design was proposed and then refined as a result of discussions with the commissioning group.

The current evaluation design was based upon an essentially interpretivist (Smith, 1989) and constructivist (Guba and Lincoln, 1989) philosophy, and employs a multi-site case study approach similar to that used in several other ENB commissioned evaluation studies (eg Bedford et al, 1993) and many other evaluations of educational programmes (eg Crandall et al, 1983; Huberman and Miles, 1984; Smith and Robbins, 1984). Those unfamiliar with their approach to programme evaluation are referred to Schofield (1993), Yin (1994), Hamel (1993) and Brewer and Hunter (1989), as only essential details and descriptions of the approach will be provided within this report.

Case study evaluation designs generally reject positivist assumptions that imply that simple relationships between key variables can be used to provide complete explanations of educational phenomena. Many build alternatively upon assumptions that the unique characteristics of individual settings are important and that understanding of the needs to be built upon understanding the multiple perceptions of those operating within them. This study was designed therefore to take a very close look at six very different contexts within which pre-registration midwifery education was taking place, relying upon an eclectic mix of interviews, questionnaires, observations, focus groups, conferences, and documentary reviews. Such an approach follows the broad approaches and collective values of well known evaluators such as Stake (1975), Guba and Lincoln (1981), Eisner (1976) and House (1980).

It is widely accepted that evaluation designs need to be pragmatic, and often it is beneficial to include multiple methods to increase both validity and robustness (Stufflebeam, 1991). Hence in this study we have followed a design, which not only sought to involve multiple sites where pre-registration midwifery education was occurring, but which also within those sites sought to collect a wide variety of data about programme design, teaching methods, assessment methods, student and tutor perceptions and actions, along with the perspectives of many other key participants and stakeholders. Furthermore we have followed a design which has blended information and insights from specific cases with wider analysis of pre-registration midwifery education as it occurs within twenty-nine separate programmes around the country. Thus our design included a survey of all institutions as well as further opportunities for specific inputs from those working in the twenty-three institutions which were not chosen for in-depth case studies.

What then could such an evaluation design produce in the way of findings? Well, the patient reader will over the next few chapters soon be able to tell. We certainly have not assumed that our understanding of the outcomes of pre-registration midwifery education would be complete, nor have we assumed that our case study findings would neatly represent the practices to be found in twenty-nine programmes located in all sorts of different contexts and situations. Indeed we have been more than aware that even the programmes, which we have studied, have been changing while we have been studying them and will have changed again by the time this report is published and available for general circulation. Educational programmes are themselves dynamic realities, and the purpose of an evaluation such as this is to gain sufficient understanding of them to be able to contribute to processes of change and improvement.

The largely qualitative approach which we have adopted has allowed us to address in a very direct way our perception of the needs of the ENB as well as of those running pre-registration midwifery education programmes. Through such an approach we have been able to be responsive to the individualism of different programmes and to the perspectives conveyed to us by their teachers and students. Whilst doing that we have been able to keep in mind the challenges facing the ENB in seeking to promote, encourage, and accredit high quality programmes of midwifery education. Thus our job has not been simply to describe and to portray, but it also has been to analyse, to critique, and to think not only about the current outcomes and procedures occurring in pre-registration midwifery education, but also about how things can be improved, how best practice can be promulgated, and how acceptable standards for the outcomes can be defined, assessed and audited.

Lastly, as an evaluation team, we have no more right than anyone else to declare what is acceptable or what is not acceptable in pre-registration midwifery education. Our specialist contribution has been in the design and conduct of a study which seeks to operationalise standards which need to be defined and agreed by critical stakeholders in their field. Thus in our research and in this report we have sought to expose the basis upon which such judgements can be made. As will be seen in later chapters it is our view that one cannot engage in a discussion about the adequacy of the outcomes of pre-registration midwifery education without first of all specifying what it means to be a competent midwife practitioner. As with other types of professional practice, this is not in itself at all straightforward, and a major part of our work has involved discussions with key stakeholders about how to construct such a model. On the basis of that work we will within this report be putting forward a model of midwifery competence. This is not in any way a finished model, indeed it needs to be seen only as a working hypothesis, if it is to fulfill the purpose which we have intended for it. Likewise the assessment matrix, which we have developed in parallel with it, now needs to be developed, tested and refined. Both the model of competence and the assessment matrix draw heavily upon our own original empirical research. As such they are both a representation of what competent practice in midwifery is and should be, and a framework for how that can be assessed. They are however also only a contribution to the process of developing professional education in this vital area, and they now need to be taken, tested and shaped further within a variety of settings, so that their usefulness can be optimised and taken forward in the light of the changing demands on the profession and practice of midwifery.

1.4 Methods

The EME project team in our submission to the ENB proposed to carry out this evaluation through the following approach:

1.4.1 Curriculum Review

Curriculum documents were made available to the team by institutions running three-year pre-registration midwifery education programmes. We conducted a thorough analysis of these curriculum documents using appropriate educational theories to inform this process. We also explored the interpretation of the written curriculum by those involved in teaching, learning and assessment. It was assumed that the nature of such interpretations would be crucial in understanding the implementation of the curricula in the different institutions. The review was therefore specifically focused on the model of midwifery used and how this was reflected in proposed programme outcomes. Curriculum models, curriculum content, approaches to teaching, learning and assessment, staff development and evaluation, all formed a part of the overall analytic process.

This stage of the study did more than set the scene for the study, as it highlighted similarities and differences between institutions and raised important issues for the selection of case study sites. It also provided a framework for us to compare with the observations we went on to make of the curriculum in action during our field work at the case study institutions.

The findings from this section of the study, which are explored in detail in Chapter 2, are likely to be of interest to all involved in curriculum design and evaluation. They also represent an important backdrop for the overall evaluation presented in this report.

1.4.2 Development of a Model of Competence in Midwifery

Although some specified outcomes already existed for midwifery education in terms of those laid down in statute, it was anticipated that some work would need to be done to develop a fuller model of competence in midwifery against which the existing pre-registration programme could be evaluated. We needed such a model to define the expected outcomes of all programmes of education for those wishing to become qualified midwives. Once developed such a model can offer much to all involved in midwifery as educators, students, managers, midwives or service users. We initially identified the need for such a model so that we could make judgements about the effectiveness of pre-registration programmes of education. However, we also quickly realised the benefit of such a model for assuring all interested parties that midwives leaving programmes have developed the right blend of knowledge, skills and attitudes to be competent to practise. The midwifery profession needs to know that midwives who are eligible to register are professionally competent. For this to happen professional competence needs to be defined and understood and exemplified in the programmes and written curricula of the ENB approved institutions. It was our view that a more extended model of competence in midwifery was needed, in the first place for the current evaluation study, and then for more general use as well.

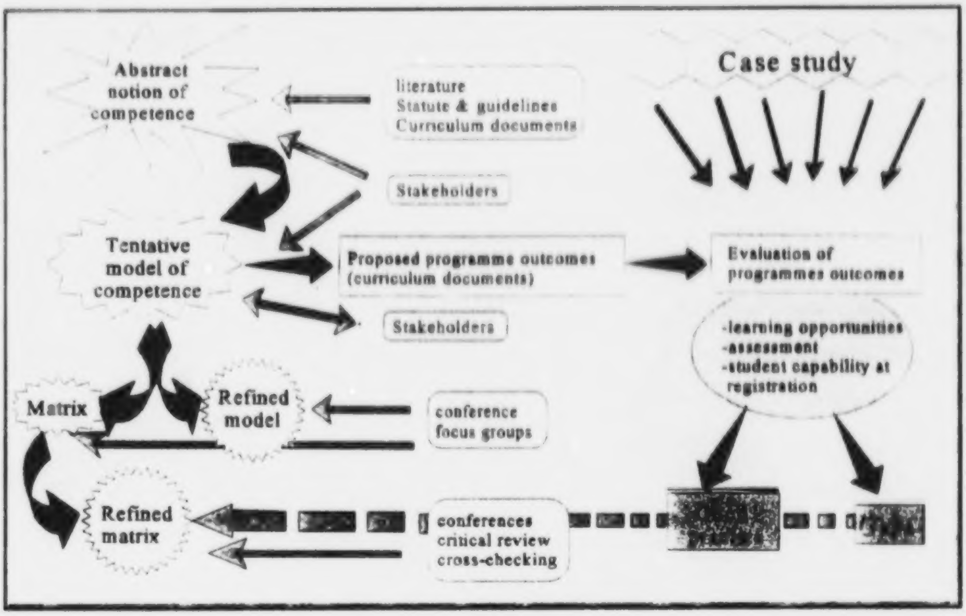
A comprehensive literature review highlighted the main issues and current ideology surrounding professional competence and its assessment. The statutory requirements for midwives and midwifery education guidelines and course documents were examined to explore the scope and likely contexts of a midwife's practice. We used a wide variety of methods, including brain-storming sessions with students, midwives and teachers, a conference open to midwives, teachers and students, group work with a pre-existing group of midwifery experts and focus groups in order to collect views from the profession. Parents were also involved through a survey and group work. These inputs from major stakeholders in midwifery helped to put the pieces of a picture of competent practice together.

Throughout the life of the project this model of midwifery competence has been tested and refined both by our project Steering Group, at conferences and in the light of our evaluation data. The final version of our model is outlined in Chapter 3. It is however in a very real sense still unfinished, and we hope that others can now test it and where necessary develop it further.

Furthermore an assessment matrix for midwifery education has also been developed for use in conjunction with the model of competence. This was developed through further work with the Professional Midwifery Advisory Network (PMAN), and through our exploration of the strengths and weakness of current assessment strategies and through focus group work (following procedures outlined by Morgan (1988)) at case study sites. This matrix, which is outlined in Chapter 10, will also be of interest to anyone involved in curriculum design or assessment, and is a further major outcome from this study.

Figure 1.1 gives an overview of the methods used and sources of data, which have been used to move us from an abstract notion of competence to an assessment matrix, and this illustrates the complexity of our multimethod approach. As can be seen, case studies were carried out alongside the development of the model of competence and the matrix and the two sides of the research process remained in a dynamic tension during much of the life of the project.

Figure 1.1 Diagrammatic overview of the research process


Abstract notion of competence
literature
Statute & guidelines
Curriculum documents
Case study
Stakeholders
Tentative model of competence
Proposed programme outcomes (curriculum documents)
Evaluation of programmes outcomes
Stakeholders
-learning opportunities
-assessment
-student capability at registration
Matrix
Refined model
conference
focus groups
Refined matrix
conferences
critical review
cross-checking

1.4.3 Matching actual and intended outcomes

The evaluation was commissioned on the understanding that a major part of the evaluation data would be collected from six pre-registration case study programmes. The case study sites were to be selected on the basis of a set of selection criteria to be agreed with the Project Steering Group. These criteria (Appendix 1) were used so that the six case studies would represent the diverse practices to be found in the thirty institutions offering pre-registration programmes. The evaluation methods used in these settings were derived from the multi-site qualitative case study methodologies advocated by Stake (1995), Yin (1994) and Greene (1994 and 1996), and discussed in section 1.3.

These case studies involved a thorough analysis of course documentation and

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detailed interviews with approved midwife teachers, course leaders, course tutors, students, and clinical assessors. The students' assessment records were also closely scrutinised and some assessors' workshops and examiners' meetings were also observed. The use of these various sources allowed us to triangulate data in building up a detailed assessment profile of each student, and of each programme. Ultimately we were able to scrutinise assessment practice across the six institutions and create a model of good assessment practice, which is presented in later sections of this report. Each of the case studies yielded rich data, which allowed us to develop a very thorough picture of the intricacies of the teaching, learning and assessment processes associated with each of the programmes. It was never assumed that these six programmes exactly represented practice in all the pre-registration programmes currently operating throughout England. We did however expect to gain substantial insights into the diversity of practice, and to be able to use that to address the concerns raised by the ENB in framing this evaluation study.

1.4.4 Selecting the sample

We have already discussed the selection of six case study site institutions providing three-year pre-registration midwifery programmes of education from all of those across England. Once these sites had been selected we then identified an appropriate cohort from each site and then selected a sample of students from within each of those cohorts. Only cohorts of students due to complete towards the end of 1994 or the beginning of 1995 were included. This was necessary for practical reasons, so that students could be interviewed twice before the end of the programme and then followed up as midwives during their first year as practitioners.

There were several issues which were considered by the team in relation to the selection of a sample of students from each of the chosen cohorts. It was important that students were willing to be included due to the longitudinal nature of the study and what was required of them. Involvement in the project included being interviewed four times, giving sensitive information to the team and volunteering others who would comment on their ability as midwives. Therefore, it was important that students were not taking part under duress or without full knowledge of the extent of what was required of them. The team felt that these issues could be addressed if students opted into the study rather than out, and were approached directly by the team who would explain, in depth, what would be required of them. Great attention was therefore paid to the processes used to recruit students for the study, and we utilised the principles on access outlined by Murphy et al (1992). Of course, there was always the risk that students would not want to be involved and that there would be trouble recruiting sufficient students to the study. In fact, this did not turn out to be a problem, and furthermore all students who had first interviews remained in correspondence with the project for the duration. In addition, most students who did not opt into the study gave permission for the team to extract data from their personal records.

Various steps were also taken to minimise sources of bias in the sample. This was done by reviewing the characteristics of the students who opted into the study as opposed to those who did not. Within the sample chosen for the study, there was considerable variation in terms of age on entry, social, career and educational background and achievement on the course. Figure 1.2 gives more detail of student background in the study cohort.

The selection criteria for institutions were devised so that the sites chosen would be likely to give a varied and broad overview of three year pre-registration midwifery programmes of education in England. Another quite separate point to note is however that the cohorts used in the study were first or second cohorts and there is therefore the likelihood that some of the issues that we have raised may by now have been addressed by the institutions through ongoing evaluation and course improvement.

1.4.5 Data Analysis

Hamel (1993, page 45) outlines some of the difficulties involved in analysing data generated using multimethod case study designs, or deconstructing and reconstructing data in a sociological form. This difficulty comes from the variety of methods and sources of evidence. Yin (1994, page 102) describes analysis as "examining, categorising, tabulating or otherwise recombining the evidence to address the initial propositions of the study". Accordingly the "ultimate aim" is to "treat the evidence fairly, produce compelling analytic conclusions and rule out alternative interpretation".

All data collected through the above phases of the evaluation have been stored, coded and analysed following a strict set of procedures (Appendix 2). The data have also been handled in accordance with a set of ethical guidelines agreed with all participating institutions and students (Appendix 3). For this reason no individuals or institutions are named in this report, and it is hoped that this anonymity will protect both individuals and institutions whilst retaining the very rich contribution which detailed naturalistic data can make to a study of this kind.

Figure 1.2 Study cohort : Student background on entry to programme

AGE	*n*	%
20 or younger	13	33.3
21 to 25	6	15.4
26 to 30	5	12.9
31 to 35	6	15.4
36 to 40	7	17.9
41 or older	2	5.1
Total	*39*	*100*
MARITAL STATUS	*n*	%
Married	21	53.85
Single	16	41.03
Other	2	5.12
Total	*39*	*100*
DEPENDANTS	*n*	%
Children	22	56.4
No children	17	43.6
Total	*39*	*100*
ENTRY QUALIFICATIONS	*n*	%
Degree	4	10.3
BTEC / HNC / HND	9	23.1
A level	13	33.3
O level / GCSE	13	33.3
Total	*39*	*100*
PREVIOUS OCCUPATION	*n*	%
Professional / Semi-prof	9	23.1
Skilled	22	56.4
Unskilled	2	5.1
School leaver	4	10.3
Other / not known	2	5.1
Total	*39*	*100*

Interviews with students, their assessors and teachers were transcribed and the main themes were identified through an analysis of a selection of transcripts. All interviews were then coded using these broad themes. This was then followed by re-analysis, site by site, to identify specific issues within each of the original themes. Documentary analysis enabled comparison between intended outcomes and actual outcomes. Curriculum documents were the main source of data about the intended assessment schemes. These were then mapped against completed assessments, assessment guidelines, examination papers and marking criteria to give a fuller picture of the operational assessment procedures.

Analysis of the interviews combined with documentary analysis has allowed a fuller evaluation of the assessment procedure to be conducted. This was done initially site by site and was followed by comparisons between sites to identify examples of good practice and deficiencies or gaps in assessment. This has resulted in the generation of recommendations for good practice in assessment. These recommendations also reflect the need for there to be national agreement about the expected capabilities of a student at the point of registration.

1.5 Project Outcomes

During our study we have explored a variety of issues which emerged from our data. We would expect these to be of interest to many individuals involved with midwifery as students, practitioners, assessors, teachers, supervisors of midwives, managers or service users. They included:

- Review of current programme curricula
- Development of a model of midwifery competence
- Exploration of attrition
- Evaluation of actual outcomes of programmes

- Evaluation of current assessment strategies
- Guidelines for effective assessment and assessment matrix
- Guidelines for effective assessor preparation
- Examination of support and learning needs of students following registration
- Exploration of career patterns and retention rates
- Difficulties associated with failing students.

CHAPTER 2

CURRICULUM INTENTIONS

2.1 Introduction

This chapter provides an analysis of the twenty-three three-year pre-registration midwifery programme curriculum documents provided for the study. It is recognised that documents are the formalised thoughts and plans of a particular group of diverse individuals, transferred onto paper in a particular style. The written curriculum is then interpreted by the teachers, and others, into at least the activity of teaching, learning and assessment. The process of interpretation and carrying out that interpretation is highly dynamic, quite unlike any curriculum document. Thus there is always an abundance of non-documentary data for programme analysis which was not included in this chapter.

The analysis is therefore an interpretation of the proposed documented implementation of the curricula, using educational theory to substantiate and help interpret where appropriate. It is also acknowledged that the curriculum documents have subsequently been modified by the institutions in the light of experience of implementing the programmes.

In Chapter 1 we have outlined the history of pre-registration midwifery education and the context of considerable change and transition within which programmes were set up and have developed. It is also the context within which many of the original curriculum documents were drafted and validated and this interpretation must be read with this context in mind.

2.2 The Documents

It would appear that these curricula were written primarily for the validating bodies, that is for the ENB and the relevant university, rather than for use by the institutions themselves after the programmes have received validation. The ENB publishes Regulations and Guidelines for the Approval of Institutions and Courses which are regularly updated, to assist in the design of programmes and the compilation of curriculum documents. Programme content is contained within programme specific ENB publications (ENB 1987, revised in 1991 and 1994). In spite of different higher education institutions validating the programmes, the presence of such guidelines and publications, as well as networking by midwife teachers, no doubt led to the high level of similarity in these curriculum documents.

Though the documents are similar in one sense, there are noticeable differences of two kinds:

(i) differences in the quality of the document itself - some are exemplary in terms of being well articulated, signposted and user-friendly, whereas others are impersonal, bland with a somewhat bureaucratic language and form and in need of editing;

(ii) differences in emphasis and organisation - for example, the content having more (or less) biological/behavioural sciences; the teaching, learning and assessment being more (or less) student centred. The claim in the course documents is that practice is used to generate theory which in turn increases the professionalism of midwifery practice, compared to practice being centred on the application of relevant theory.

2.3 The nature of the midwife and of midwifery

All of the curriculum documents reviewed quoted from and referred to the common statutory/international reference documents.[1] Thus a common definition of the midwife was used upon which all programmes are based. This definition needs to be interpreted and articulated within the description of the various curriculum documents and programmes and there is conformity at this level also; the basic description of the midwife appeared to be very similar throughout all the institutions.

The model of an effective midwife as described in the curriculum documents is that they are reflective, research-based, autonomous practitioners who contribute to the development of their profession. They work in partnership with women and their families, using at all times, a problem-solving, individualised needs-meeting approach, with relevant up-to-date knowledge and appropriate, flexible attitudes to care. They are accountable, evaluating their practice as part of caring and gaining confidence in the process. Their role includes health promotion, and the education of parents and colleagues. Life-long learning by the midwife is essential if they are to meet the challenge of change both within and outside their profession.

This model of the midwife greatly influences the concept of midwifery, which can be found in the curriculum documents. There are, however, other factors that influence that view of midwifery, for example, there is an assumption in the documents that most women of childbearing age are healthy and that childbirth is a natural process or an altered state of health. Thus, mothers, babies and families at risk are special cases, and are treated as such. The student midwife learns her professional practice initially by observation while normal mothers and their families are being cared for, later she will participate in care and then extend her practice to those who are at risk or those who develop complications. Individual care is built around a four stage process, namely, assess, plan, implement and evaluate care. A few programmes name specific models of care well known in nursing, such as Roper, Orem, Roy, and adapt them to midwifery whereas others adopt midwifery models (eg Henderson). Providing total care is recognised as a multi-professional activity; thus though midwifery is unique and autonomous, cooperation and liaison with the other caring professionals is vital always, not only in an emergency.

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[1] World Health Organisation (1969), International Confederation of Midwives (ICM) (1972), International Federation of Gynaecologists and Obstetricians (FIGO) (1973) HMSO Statutory Instrument 183 Nurses, Midwives and Health Visitors Act 1979, UKCC Midwives Rules (1986), UKCC, Standard, Kind and Content of Midwifery Education to Registration as a Midwife.

Importantly, all the programmes see midwifery practice as requiring the application of theory, especially scientific theory, the biological, psychological and social sciences. This is the traditional view of practice built around a single model or paradigm, namely, "professional activity consists in instrumental problem-solving made rigorous by the application of scientific theory and technique" (Schön 1983: 21). Since reflection, that is, reflective practice, is seen as central to the midwife's role in all curricula, it is somewhat surprising to find that the traditional model of professional knowledge based on positivist epistemology still appears to dominate in these midwifery curricula.

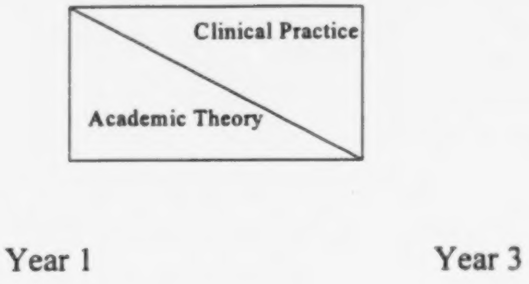
2.4 Professional Education

According to Schön (1983) then, the dominant view of professional practice is "technical rationality": he questions why this view requires "very little justification" even though it permeates "our universities, embedded not only in men's minds but in the institutions themselves". The hold is so strong that it is built into the assumptions of Western society and as such has become dogma. These midwifery curricula appear to support Schön's view of the power and all pervasiveness of the "technical rationality" model of practice.

One consequence of this model is a split between theory and practice so that it becomes "the business of university-based scientists and scholars to create the fundamental theory which professionals and technicians would apply to practice" (Schön 1983: 36). And this task split came to have an in-built status split as well. Medicine became the institutional model to which other professions aspired for "here was a solid base of fundamental science, an equally solid body of applied clinical science, and a profession which had geared itself to implement the ever-changing products of research" (page 38).

Another influence of the technical rationality view of practice on professional education can be seen in the curriculum structure for the initial education of professionals. If professional practice is seen as a process of instrumental problem-solving made rigorous by the application of scientific knowledge, scientific theory needs to be known by the practitioner before it can be applied to their practice. This necessitates a curriculum structure of theory first and practice later. The scientific theory is always highly selected and in all of these programmes the central core is biological, psychological and social sciences.

All these pre-registration midwifery programmes adopt this structure, more hours being timetabled initially for theory than they are for practice (for example, 240 hours theory and 120 hours practice; 320:104; 420:105; 170:0). Often the first year/term is described as a Foundation Course, where the selected theory is taught in disciplines and often assessed as separate disciplines too. Thus, the traditional curriculum structure for initial professional education is a double wedge:



This diagram was drawn in two curriculum documents as fundamental to their curriculum design: it is used by all others, possibly in response to ENB requirements to assess theory and practice. It seems that these educational innovations have not questioned sufficiently the paradigm of professional education and its assumptions of knowledge based on positivist epistemology with the result that those have been reinforced by the innovations.

Other curriculum models currently adopted in clinical professional education are (i) problem-based curricula, which are typically practice-based problems presented to students, and these problems control the curriculum; and (ii) community-based curricula, which include substantial experience of actual practice from the very beginning of the programme. Neither of these two models is described in these pre-registration midwifery programmes.

2.5 Knowledge

All of the pre-registration programmes reviewed had selected three academic disciplines, namely biological, psychological and social sciences, to extend throughout the three years. Their timetabled hours decrease over time, so that the greatest input is in Year 1, when students are least experienced in midwifery practice. This conflicts with the findings in a recent ENB study where "front loading of scientific knowledge" was found to be "exceedingly wasteful, because without linkage to practice it is quickly forgotten and has to be repeated later in the course" (Eraut et al 1995).

Other theoretical matters, which were included to a greater or lesser extent, are the theory of:- Communication, Interpersonal Relationships, Education, Information Technology, Ethics, Management, along with Research Methods which is always included. Midwifery Theory is likewise always included, as also are what might be broadly termed Nursing theory as applied to midwifery; Health and Health Care; Childbearing, Birth and Development. Most institutions show a continuous, gradual decrease in timetabled time for theory (especially what might be called the three basic academic sciences) but this may not be a smooth continuous decrease as there are sometimes fluctuations in this overall downward trend, whilst three curricula incorporate an increase in timetabled time allocated to theory in the final unit of their programme.

Seven programmes explicitly see practice generating theory. This is described variously as "professional knowledge", "practice informing practice", "deducing theory from practice", "students and teachers contribute to the development of knowledge" etc. However none of them strongly link this generation of theory from practice as the mainstay of research-based practice which all the programmes espouse. Theory generation is variously described as "increasingly professional knowledge", "informing further practice", "further theory is deduced from practice", "the education of students and teachers contributes to the development of knowledge". An activity which shows some of the characteristics of theory generation from practice is found in nine course documents (including five of the seven above). Here the midwife after giving care reflects on both the care and the outcome, reinterprets the situation (this may match or mismatch previous interpretations) leading to changed or reinforced practice. This activity was given great emphasis by only three programmes. Given that valid practice generated theory is significant theory for that practice it is perhaps surprising that the generation of theory from practice was not evident in all curricula.

Interestingly, nearly all the programmes contend that the relevant, taught theory would be "integrated" or "synthesised". Two curricula do not stress this but imply interpretation and synthesis of knowledge are present in their definition of midwifery care. Views of professional knowledge (and underlying views of reality) are clearly important and require, suggests Eraut (1994a, 1994b) more critical analysis when reflection, integration or synthesis are at issue. If knowledge, reflecting one view of reality, is seen as a "seamless coat" (Becher and Maclure 1978) then integration or synthesis is much more achievable, indeed it is called for. If, on the other hand, knowledge, reflecting another view of reality, is seen as compartmentalised, then discipline boundaries will be maintained and even extended making integration or synthesis unlikely.[2]

Integration is an interesting term in education, especially in relation to professional education courses which require achievement of competence (Laurillard 1994). The term integration is thought to derive from primary education for example as in the integrated day, and the integrated curriculum. The aim here is to minimise divisions between disciplines as they are thought to be artificial and inconsistent with how learning actually occurs. Importantly, integration allows the learner freedom of choice, since it is the activity of learning which is regarded as the central focus of the educational process rather than learning particular selected content. This view of education provides a practical framework for a student centred curriculum and individual learning. It may be that midwifery education would achieve the necessary outcomes to practice more effectively by a curriculum which was not organised around pre-selected disciplines, but where the activity of practice determined the curriculum content spontaneously. Such a curriculum would lead to integration both of subject disciplines and of theory and practice since mothers, babies and their families are the natural and best focus for any integration. Such an approach would be compatible with student-centredness and individualised learning philosophies, which are included in all curriculum documents to a greater or lesser degree, but could cause difficulties for timetable management and would need to be carefully monitored.

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[2] A complicating factor is thought to be that participation by staff in programmes which aim to achieve integration or synthesis may jeopardise career prospects (Hewton 1982: 41): academic institutions are built around discipline boundaries.

Bernstein (1971) suggested a model which can be used to determine the nature of process of any course. He distinguishes two types of curricula, namely integrated or collection. These, he claims, can be identified by using two separate dimensions of description: (i) classification of knowledge and (ii) framing of knowledge. "Classification ... refers to the degree of boundary maintenance between content" (page 49) and "frame refers to the degree of control teacher and pupil possess over the selection, organisation and pacing of the knowledge transmitted and received in the pedagogical relationship" (page 50). Strong classification and strong framing characterise a collection-type curriculum, whereas weak classification and weak framing characterise an integrated curriculum. Bernstein claims that an integrated curriculum is more difficult to achieve the more teachers are involved, since control of the kind of classification and framing is much more problematic. In secondary education, Ball (1981) found that science teachers were likely to put the needs of their discipline before the needs of an innovation or their children. In the current climate of quality control and audit, midwifery curricula will need to guard against constraining innovation as providing evidence of teaching quality could demand more organisation, rigid structures and packaging.

The process of the curriculum, or the course-in-action cannot be determined from curricular documents, i.e. the course-on-paper. The midwifery curriculum documents include statements about process, but statements cannot guarantee that what is intended is enacted. All curriculum documents articulate philosophies, strategies and management personnel to implement the programmes. However, the general principles outlined by Bernstein (1971) and Ball (1981) cause some concern when applied to the midwifery programmes, for an integrated process or approach is what midwifery, like all professions, required because of the complexity of present day practice - the bread and butter of the professional activity - and the need to bring knowledge and experience into harmony rather than making them divorced from each other.

These midwifery curricula documents are generally designed around content rather than process. They focus on what students should know, rather than on how they should learn. It was the early years of professional education programmes that focused on content: the later years were governed by practical experiences. However, because midwifery education is now outcome based, the focus on content has been strengthened throughout the practice years as well. These midwifery curricula are no different to the rest, especially in terms of timetabled hours. Traditionally though, attention is also paid to teaching/learning, i.e. the 'how' of the curricula, in the curriculum documents. Chosen content is structured in these programmes so that it is taught from the simple to the more complex; such progression is stressed in all but two curricula. Terms used to describe the progression are, for example, "developmental", "a spiral curriculum with higher levels of understanding later". Movement from simple to complex is also expressed by teaching and learning about health before illness (though epistemological concepts of health are derived from knowledge of illness, disease or indeed illness via experimentation, hence in this sense health is a more highly developed and subtle concept than illness), and the normal before the abnormal (epistemologically the same applies to normal and abnormal, as applies to health and illness). Not all students are best served by such a simple to complex progression. Probably, neither is midwifery practice, and in practice settings no doubt students do not experience this controlled progression.

Almost a century ago Dewey (1910) drew the distinction between "science as subject matter and as method". He passionately believed that "science has been taught too much as an accumulation of ready-made material, with which students are to be made familiar. Not enough as a method of thinking, an attitude of mind, after the pattern of which mental habits are to be transformed". When Dewey called for less science content (the what of education) and more science method (the how) many science disciplines were in their infancy: with the explosion of factual knowledge it is easy to see how curricula can be overloaded with content. This is certainly the case in professional education modelled on "Technical Rationality" and it is in effect the method of science which these curricula appear to call for to influence the thinking of midwives.

2.6 Teaching and Learning

Aspects of teaching and learning have already been considered therefore this section will focus especially on the interaction of teachers and learners. All of these programmes recognise the differences in the way students learn. Teaching is organised in a variety of ways, for example, lectures, seminars, tutorials, workshops, also discussion of diaries and journals, and individual supervision for clinical placements, surveys, projects; sometimes counselling is included as a teaching activity. Various amounts of time are given to self-directed study, directed studies and to reading weeks.

The early years of the curriculum are, in the main, timetabled for the selected subject matter (the curriculum content) to be taught largely as separate disciplines, namely Biology, Social and Psychological Sciences, along with Midwifery Theory and Practice. Bernstein (1971) showed how strongly bounded subject fields, essentially disciplines independent of each other, and selected by teachers and/or the curriculum, lead to what he termed a "collection-code curriculum". Many of these midwifery programmes adopt this pattern in Year 1, even though (i) they involve midwives in the design and evaluation of the curriculum, and (ii) wish to develop their students as active adult learners.

Another outcome of such a discipline-focused curriculum is, according to Eisner (1990) that "subject fields are taught mainly through text and other propositional forms" (page 93). He continues "as our understanding and appreciation for multiple ways of knowing grows, there is greater likelihood that more synthetic, integrated curriculum will be developed". Professional action such as midwifery, where the variables are great and predictions uncertain, requires multiple ways of knowing if effective care is to be achieved. Multiple ways of knowing (Polanyi 1962a, 1962b; Carper 1978; Eraut 1984, 1985; Shannon 1991) need to be recognised and valued by programmes; these different ways need to be part of education more overtly. It should also be recognised that traditional methods of assessment, notably examinations and essays, are inappropriate for some of the ways of knowing. This has been recognised by many institutions who are now further developing their assessment strategies.

Ways of knowing influence teaching since all teaching embodies a particular view of knowledge (Barnes 1976; Beers 1988; Eisner 1990). The organisation of teaching reflects the teacher's view(s) of knowledge; it determines the relationship between teachers and learners and also the nature of the student-learning outcome.

The teacher/student interaction in the first year of the midwifery curriculum is in large part based on theory acquisition (most timetabled hours allocated to theory) and consequently on the transmission of knowledge as facts and information which are then concurrently used to varying degrees in the context of midwifery practice. Such an emphasis on theory as facts and information may at the same time effectively change the student midwife's view of knowledge, and their learning strategies; students' view of practice could be influenced as well, the 'technical rationality' model (the application of scientific theory) becoming more firmly established. These changes are likely to be greatest where students' practical experience is least. Some of these midwifery programmes have few hours timetabled practice compared to timetabled theory. It will also be greatest when students are taught by non-midwife teachers: the first year of all the programmes have the biggest input from non-midwife teachers. Thus at the time when students are most 'vulnerable', they experience the greatest influences on their fundamental paradigms of knowledge, teaching, learning, and especially professional practice.

All the programmes wish to be student-centred and to achieve personal development and awareness as well as high academic and professional standards. To this end the programmes' approach to student learning is that of Knowles (1984) the adult learner where students are given responsibility for their own learning and encouraged to be autonomous and self-directed. Negotiated learning contracts and projects are good examples of this approach; both are included in all programmes at some point(s) during the three years. It is intended that such an educational experience will provide life-long learning by students.

However, though programmes recognise differences in students' learning styles and approaches, no details are given of the styles or the approaches or of the implications and consequences other than requiring match between the teaching and the learning. Only one programme document identifies or names possible styles: they use a four type model, "activist, reflectivist, pragmatist, theorist" (no source is given, but is probably that described by Honey and Mumford, 1982). They acknowledge that some students "are able to utilise a combination of styles". But like other programmes, they hope that by using a variety of teaching methods, some match to student learning style will occur, some of the time. It would appear that a rather hit and miss strategy is favoured, and there is little evidence that they would encourage students to vary their learning style according to context, or goal, as suggested by Laurillard (1979, 1994) and Miller et al (1994).

Two learning styles (not identified in any of the documents) that have proved influential in student learning are the Holist and Serialist styles. Pask and his associates (Pask and Scott, 1972; and Pask, 1976) designed experiments to test the idea that people who are taught in a style which does not match their normal learning strategy will be disadvantaged compared with people who are matched on learning strategy and teaching style. Broadly speaking the Holistic style learner conceptualises the task as a whole, anecdote and synthesis are important and a divergent cognitive style is evident. It is fostered by informal teaching methods and by the arts/humanities. On the other hand, the Serialist style is step-by-step, logical, analytical and with a convergent cognitive style. It is fostered by formal teaching methods and language, science, and maths disciplines. In 1976 Svensson (cited by Marton et al, 1984) also identified two main variations in cognitive approach, but instead of a serialist style, he described an atomistic approach. Students who adopted this approach were able to memorise details of the text but were unable to demonstrate evidence of grasping the whole message. Midwifery practice, if not midwifery theory, could benefit from both styles; therefore the curriculum needs to provide for both all the time. The curriculum documents are however based more on a serialist approach. Not only does it appear that disciplines are taught separately, often examined separately too by discipline experts, but they are introduced in a graded way, sequentially from simple to complex, from normal to abnormal or at risk. Clearly such a curriculum greatly favours serialist style learners no matter whether the content is presented as a lecture, tutorial, seminar; even self-directed learning where the required content is serialistically organised does not help a holistic-style learner nor help students develop different learning styles.

Just as theory is arranged serially or progressively, so is practice. Programmes provide for students in practice placements to observe firstly, and then to increasingly actively participate. There is evidence to suggest that active participation needs to be provided from the beginning (Kent et al 1993); it goes without saying that all active participation in practice by professionals and novices alike, must be always safe. In order to facilitate the development of different learning styles it would seem helpful to provide for both observation and active participation from the beginning, depending on the learning goals at the time.

Though learning styles are recognised by all programmes, what doesn't appear to be recognised in the programme documents are student learning approaches which are manipulated by the context or the learning environment. Marton (1976) observed that students adopted a surface or deep level of processing information according to context or content and Entwistle (1981), Entwistle and Ramsden (1983) found the term processing to be too narrow in relation to differences in learning and went on to identify three approaches to learning:

(a) Surface approach: students tried to predict the questions they might be asked: this was a central focus of their reading and they memorised the information to answer these questions, ie their learning was by rote. They did not try to link the new knowledge to what they already knew; their level of information processing was low. These students were teacher dependent: they wanted and aimed to please the teacher - they were convergent. Convergency accompanies a serialist style, so that serialist-learning students readily adopt a surface approach to their task.

(b) Deep approach: students tried to understand the passage linking new information and facts to their existing knowledge and experiences; thus their level of information processing was high. They looked for the validity and cohesion of the author's argument, their learning was meaningful. These students were not teacher dependent: though they looked to teachers, and those who knew more or had more appropriate experience than they had themselves to provide feedback and guidance. They could also cope with uncertainty and take calculated risks. Such an approach is central to professional practice.

(c) Strategic approach: Students were very competitive; they wanted to gain high grades so they organised their time and effort according to the "pay off" in assessments. They were attentive to the hidden curriculum (Snyder 1973) using surface and deep approaches as they saw fit.

None of the midwifery programmes, nor professional practice, would welcome a surface approach; though the serialist organisation of content with tight classification and framing of knowledge demonstrated by these curricula will not discourage a surface approach. A deep approach is required, especially for competent practice in changing situations. However, this approach would be best served by experiences of authentic practice so that understanding of all theory could be practice based. In this case theory would probably influence practice; currently knowledge of particular theory is no guarantee of its influence on practice. A strategic approach is in effect a learning approach to outwit the demands of curricula. It can be considered as a learning pathology - students pretend to be what they are not, and to know what they do not know, establishing a "cloak of competence" (Haas and Shaffir 1982).

A further point concerning the deep/surface dimension of learning is that students who say they are interested in a topic/subject (intrinsic motivation) tend to adopt a deep approach to learning. They develop creative understanding. Students who say they are anxious tend to have a surface approach to their work. They learn by rote. An interesting feature which is often overlooked in teaching and learning is that teachers' assessment of students' interest and anxiety is not linked statistically to either a deep or surface approach to learning by their students. It seems that only students themselves can validly judge if they are interested or anxious.

For a long time it has been recognised that students' academic self-concept is also an important influence on learning (eg Sears 1963) as it controls what students believe they can get out of and put into their programme. It is heavily influenced by peers and the institution. Broadly speaking it determines what students expect of themselves. The curricular documents with their student centredness give the impression that students will be supported, even cherished. This should enhance student learning. However, it should be remembered that when students are criticised for lack of ability (rather than lack of effort or interest) their academic self-concept may be undermined.

Whilst student learning styles and approaches are important, since they control the way knowledge is structured in memory, it is also important for students to be able to develop "a flexible response to an accurately perceived situation" (Miller et al, 1994, page 10). The pre-registration midwifery curricula need therefore to pay careful attention, especially in the early years, to the details of student learning. Lectures and text books do not structure knowledge in a practice-based way (Kriel et al, 1988) so that knowing a lecture or a text book may not help students improve their practice reasoning abilities. Whilst it might be evident that curricula should facilitate a deep approach to learning by students, Laurillard (1994) stresses the importance of helping students with mapping strategies and integrating subjects. These midwifery curricula whilst emphasising the importance of in-depth knowledge and reflective processes, fail to provide evidence that midwife teachers will help students to integrate midwifery theory and practice early on in the programme.

2.7 Assessment

In line with ENB Regulations and Guidelines (ENB) (1990) programmes have what might be broadly termed assessments of theory and assessments of practice.

Just as all the programmes recognised variety in student learning style and catered for it by a variety of teaching methods, all programmes recognise that different students are able to do well at different tasks and so they offer a variety of assessment types, for example, essays, journals, care studies, seminar papers, surveys, projects, also written timed examinations both unseen and seen, including open book. However, it is not certain that these different methods test different forms of knowledge, and multiple ways of knowing that are required by professional practice. The assessments in practical placements extend the aspects assessed.

There are both formative and summative assessments for all programmes. Most programmes give a grade equivalence for percentage marks and general criteria that match these mark/percentage categories. However, though marks and categories along with general criteria may give the impression of criterion marked assessments, this would probably be a generous interpretation. The criteria are not standardised criteria generated and moderated by a board or committee that functions across institutions. The external examiners' role is to establish comparisons of standards and fairness across boundaries or departments and institutions. But this is by a process of expert consensus rather than standardised criteria. This method of expert consensus seems wholly appropriate and especially so in professional education programmes.

All institutions have well worked out assessment management structure and procedures, including an appeals procedure. Also, details of procedures for discontinuation of students. There is, of course, no indication of how often these procedures need to be activated. All students need to fulfil the assessments of one part of the programme before they can continue onto the next part; this applies to theory and to practice assessments and reflects the ENB regulations relating to continuous assessment that applied at the time (ENB 1990, pages 49 - 52, now 1996, Section 5).

The majority of programmes assess the foundation sciences - Biological, Social and Behavioural, in their applied contexts, via care studies, for example, but six institutions test these sciences as separate disciplines initially, before they are tested in their application to midwifery practice. These methods of assessment, especially the latter, reinforce the traditional model of practice and the serialist approach to learning. The espoused view of midwifery care is holistic in all cases: perhaps the assessment procedures could reinforce this view more effectively.

Not all institutions provided complete assessment of practice documentation. A sample was however normally included in the main curriculum document. Midwifery competence can be implied from the Midwives' Directives 80/155/EEC Article 4 (Appendix 4) and 89/594/EEC Article 27 (Appendix 5) which are themselves in line with the WHO definition of a midwife adopted by the International Confederation of Obstetricians and Gynaecologists in 1972 and 1973. The UKCC Midwives' Rules, together with the English National Board

Regulations for Courses are incorporated. Assessment in practice takes place in a variety of settings: in this respect the assessment might be called a 'real world assessment' via performance demonstration and discussion/interview. There are two elements or purposes: (i) they provide a basis for planning instruction, tailored to specific situations and individual student needs; and (ii) they permit comparison of progress for each student and standard reached, since assessment is frequently measured according to levels.

There are at least four potential problems with any assessment via levels: in assigning a level to be achieved there is (a) an implied denial of competence at a higher level, at the particular time of assessment; (b) an implied assertion that competence at the judged and recorded level once achieved remains achieved; (c) the assessment emphasises the fragmentation of competence into small and separate parts whereas the nature of competence is the successful synthesis and integration of very many different factors into a unified, coherent whole; (d) students and assessors alike may begin to construct a conscious view of practice as a collection of separate entities to be acquired and assessed individually.

In many institutions assessment in practice is based on the four stage model of midwifery practice, namely, assessment of care needs, planning, implementing and evaluating care given (UKCC Rule 33 Outcome 3c iii could possibly have influenced this model). Other threads that form part of the assessment schedules are professional attributes such as confidentiality, communication, working as a team, record keeping, management and provision of safety, technical skills and teaching.

Whilst most describe the assessment approach as one of problem solution, none of the curricular documents explicitly incorporate problem design into the process, and according to Schön (1983) problem design is at the centre of practice rather than problem solution: "in real-world practice, problems do not present themselves to the practitioner as givens. They must be constructed from the materials of problematic situations which are puzzling, troubling and uncertain" (page 40). Constructing problems is an act of design (Cross et al 1986), or, differently expressed, "problem setting is a process in which, interactively, we name the things to which we will attend and frame the context in which we will attend to them" (Schön 1983: 40). Handy (1984) sees the activity of reframing as imaginative and creative leading to conceptual breakthroughs and the basis of inquiry. Reframing is especially valuable in changing situations or non-rule governed activities: this is the view of midwifery practice espoused by the programmes - problem design or problem framing and reframing should not be neglected.

It would appear from the small sample of assessment documents provided by institutions that assessment is broken into a series of separate though related parts. Experienced midwives have expressed doubt as to the value of using a competency-based style of assessment as a way of determining a student's ability to provide holistic midwifery care (Worth-Butler, Fraser and Murphy 1996). This dilemma is not unique to midwifery and has been one of the main debates surrounding the use of NVQs in the professions (Mitchell 1993, Smithers 1993). It could be argued that an atomistic style of assessment tends towards role base, task oriented practice and education as product or achieving behavioural objectives. One curriculum document expressed a switch from education as a process model for theory, to education as a product model for practice. There seems to be tension here between the expert, complex view of competence and professional practice versus the behavioural, objectives view of what competent professionals do in practice, a role-based model. Reaching a clear understanding of the concept of competence however is problematic. A recent report from the National Board of Scotland (1995) suggests that there is a need to incorporate the "murky area of suitability" when assessing fitness for professional practice. These midwifery curricula assume competence to be clearly defined, the end point of the pre-registration programme, whereas others such as Dreyfus (1980), Benner (1984) and Eraut (1989) describe professional competence as a continuum such as from novice to expert, although it still remains an over-simplification of the concept. An end-point is still implied and is not what successful practice and lifelong learning is all about. A further complication of emphasising a reductionist style of assessment is that it favours a serialist learning style.

It is likely that these locally developed assessments of clinical competence are considered highly relevant by those midwives who designed them. They may seem less relevant to midwives who use them. And like all locally developed 'tests' they are limited to the extent that they are neither norm-referenced nor criterion-referenced in any theoretically based, systematic way. This prevents comparisons across programmes: perhaps comparisons are not needed. But validity and reliability are needed as they are essential features of any assessment, and for locally developed tests the validity and reliability are unknown. Without knowledge of their validity and reliability it is difficult for an 'outsider' to interpret any score/level with confidence. 'Insiders' may have more confidence in the score/level because they know the student and/or because they might have tested their scheme. Assessment of competence by portfolio is an alternative which some institutions have incorporated and is recommended in the ACE project report (Phillips et al 1994). Teachers who use portfolio assessment consistently say how much they learn about their students and what a useful, flexible method it is since it redefines the scope of assessment. Portfolio assessment also promotes professional development and practitioner inquiry (Cochran-Smith and Lytle 1993), qualities at the centre of their innovative curricula.

2.8 Staff Development and Programme Evaluation

Staff development is a concern of all twenty-three programmes. Clearly there is a realisation that there can be no curriculum development without staff development. But staff development is no easy matter in professional education; the number of staff involved is very large but number of staff is much less a problem than variety of staff. Helping a professional physiologist who is expert in their field of renal metabolism, say, to gain insight into (a) the course and its aims, and (b) the diversity and needs of the students who are not the typical academic student group, and (c) the practice of midwifery, is a very different task to helping a community midwife understand the innovations. Without an understanding of the course and its broader context, it is not possible for staff to contribute appropriately, as the programme intended.

A majority of programmes describe ways in which their clinical placement staff are involved and helped to understand their role. Circulars, newsletters, memos are typical means of giving information. These are supplemented with purpose designed workshops and study days which occur regularly, 3 or 4 times a year, for assessors. The programme also demands that assessors have at least six months (or preferably more) midwifery practice; the ENB 997 course "Teaching and Assessing in Clinical Practice" is desirable. Assessor guidelines have been designed in most cases and the link/liaison teachers together with student personal tutors can offer further on-going support and development.

The help given to the academic discipline based staff has to be assumed: it is not described as such. If they have contributed to the design of the curriculum, this will provide insight and considerable development. However, there is no evidence of a formal mechanism for this to cascade to others within their department and across departmental boundaries. Setting and marking assessments and examinations if they relate to midwifery practice will also provide their own highly relevant insights. Courses espouse a humanistic educational process: wherever this is achieved staff will benefit by sharing student knowledge, perceptions and experiences.

Programme evaluation is also an effective method of providing staff development if staff are involved in the process and helped to interpret and use the findings. All programmes audit the placement areas, an ENB requirement, though not all documents highlight this. It is probable that they all evaluate via assessment/exam results as well as other methods, such as questionnaires to and interviews with, staff and students. All methods may be used both formally and informally. Evaluation (including monitoring) has an important part to play in any curriculum innovation. However, in order to play that part staff and students need to be involved and the findings need to be used and be seen to be used. Effective evaluation is very powerful in many ways, only one of which is staff development. If evaluation is ineffective it may be less than useless as staff and students alike may be lulled into a false sense of security.

2.9 Curriculum Content

A major part of each programme document is devoted to outlining the curriculum content, i.e. the what of teaching and learning. Such a relative proportion is common practice in programme documents, so much so that it may be the only topic attended to in detail. Happily this was not the case in these midwifery documents.

Most programmes have three or four parts, the first part being a foundation to the whole programme; though the parts in some programmes are not clearly distinguished. All have programmes divided into units with 20 units maximum.

Themes or course areas/core subjects are also present; again variable in number forming the framework for midwifery practice. Where there is little grouping of discipline content, there is a variable number of themes, for example Midwifery, Health, Health Care Provision, Sociology, Psychology, Philosophy/Ethics/ Politics/Spirituality, Biological and related sciences, and Research; these are in effect core subjects. Where grouping of disciplines occurs, there is the minimum number of themes, namely 3 - midwife practitioner, educator, manager.

Curriculum organisation following Bruner's (1960) spiral curriculum model is most common; curricular areas are taught from the simple to the complex. The simple are revisited in greater detail as part of the complex (Bruner 1966; Ausubel 1968) and the value of prior knowledge is emphasised (Ausubel 1968; Bruner 1966). An example taken from midwifery theory and practice of simple to complex themes/units which matches closely the sequence of practical placements is: - The childbearing family, Care in childbearing, Normal midwifery in the community and hospital, midwifery related nursing theory and practice, and high risk mothers and babies.

Utilising the simple to complex model readily incorporates Bloom's taxonomy (edited 1956) and Taba's (1962) levels of knowledge which are then linked to assessment. Such an approach fosters Tyler's (1950) product view of knowledge and education: this view is compatible with the levels of competency assessment of midwifery practice around which many programmes are developed. A different view of knowledge and education is the process view (Bruner 1966; Stenhouse 1985). Some programmes that adopt this view stress Rogers' (1969) freedom to learn approach and Kolb and Fry's (1975) four stage model of reflect, analyse, synthesise, the problem-solving cycle of the reflective practitioner.

The programme documents state or imply that a process view of knowledge is central to the programme philosophy, students are therefore active learners. But, on the other hand, the emphasis on levels of competence or achievement, and of a stepwise (simple to complex) approach to teaching and assessment is compatible with a product view of knowledge. All programmes have this basic structure which would tend to encourage passive learning, there certainly seems to be tension, perhaps conflict, between these two curriculum philosophies.

2.10 Summary

The twenty-three curriculum documents illustrate an abundance of time and effort that has gone into their production, and into the curricular design that they describe. It is appreciated that written documents with their linear order are perhaps not the most suitable way to describe curricula as a lived experience. Yet this is the importance of all curricula - their lived experience especially for students, as they are central and the raison d'être.

Clearly, all curricula have adopted the changed concept of midwifery practice. There is also agreement as to the descriptive nature of the midwife and of midwifery.

There is a danger that the Technical Rationality model (Schön 1983) controls the model of professional education, scientific theory first which when known can be applied to later practice, it also uncouples theory generation from practice, and could place severe restrictions on what counts as knowledge and ways of knowing.

All midwifery practice according to the programme documents should be research based. Unfortunately what such research would be like, or how the research findings would be used, is not always clearly articulated. It seems with the natural sciences experimental view of research (implied) that research findings would tend to prescribe practice rather than increase the quality of deliberation about practice. Contemporary midwifery practice demands a redefinition of what midwifery knowledge is, and how it can be obtained and constructed. Reflection on and in practice offers midwives a useful, if not the best, source of meaningful knowledge which can facilitate progress to holistic care.

Although Eraut (1994a) argues there is a need to reframe Schön's concept of reflection-in-action, much of Schön's work remains of relevance. Midwives need to allow themselves "to experience surprise, puzzlement, confusion in situations" which they find uncertain or unique. When someone reflects-in-action, he becomes a researcher in the practice context ... he does not keep means and ends separate, but defines them interactively as he frames a problematic situation" (Schön 1983: 68). Framing is the first step in problem solution and reframing is a creative approach to a problem. Such an approach to professional action is vital for practice based research (Bruner 1966; Stenhouse 1985) and for actual practice whenever situations are uncertain or unique as they are in the new concept of midwifery. Midwives need a clear view of practice with the multiple range of knowledge, and research as practice-based: without such a view they cannot help students effectively however committed they are.

The documents reported pedagogic philosophies and strategies with a greatly increased variety of organisation of teaching, learning and assessment. Clearly such differences in organisation will influence the educational experiences of students.

All students are assessed in clinical practice to determine their level of competence and fitness to practice. Colleges have produced their own assessment sheets largely based on practice as the assessment of need, planning care, giving/implementing care and finally evaluating care. These four related stages are described as a serial continuum; in authentic practice it is likely that they will interact much more dynamically. Significantly, problem design is absent from the problem-solving process as described. The competence-based assessment sheets, though undoubtedly derived from practice, tend to reduce practice even further and provide a rule or task based framework. The assessment sheets could constrain practice because they legitimate certain aspects to the exclusion of others. Midwifery is less tidy, and the role of intuition and qualitative thinking are more highly prized than these assessment sheets recognise as can be seen from an alternative exposition of Dreyfus (1980) (used by Benner (1982) and Eraut (1989)). This model encourages practitioners to debate practice and use ideas to suit their own practice and situation, to expand practice rather than to reduce it. It is such expansion that will confer professional status on practitioners; value needs to be given to criteria generated by professional consensus in particular contexts rather than role-based criteria or what 'institutions' think competent midwives do in practice (and by implication what they do not do).

However, it is the living experience of the curriculum which is important, not the documents. Especially influential is how teachers interpret and translate their role into teaching/learning activities. Other than this, it is the students' savoir-faire to see their way through the curriculum successfully, that counts. It is the in-depth case study part of this project which has enabled the actual curriculum outcomes to be compared with what appeared to be the intentions from an analysis of the written curriculum.

Key Issues

- All curricula incorporate the changed concept of midwifery practice and demonstrate agreement as to the nature of the midwife and midwifery (2.3)

- Curricula adopt a "double wedge" of theory first and practice later. This appears to reinforce a "technical rationality" model causing a split between theory and practice and potentially wasteful learning and less fruitful practice (2.4, 2.6, 2.10)

- Only seven programmes identify practice generating theory and there is no evidence that this should be linked to research-based practice (2.5)

- All programmes contend that the taught theory would be "integrated" or "synthesised" although evidence for this was lacking in curriculum documents due to the compartmentalised arrangement of subject disciplines, double wedges, theory and practice elements (2.5, 2.9)

- The curricula describe progression from simple to complex and learning about health before illness. This might not be the most effective way of enabling students to develop the skills for problem framing and re-framing which will be needed when the reality of practice presents uncertain and puzzling situations (2.5, 2.6, 2.9)

- Most documents appear to be based on a serialist approach to learning whereas it is suggested that students would benefit from both holistic and serialist learning styles to equip them for their role as midwives (2.6)

- Six institutions initially assess subject disciplines separately which favours the serialist approach to learning and application of theory to practice rather than the holistic nature of midwifery (2.7)

- There is a tendency to fragment competence into small and separate parts and a lack of evidence that students would be expected to successfully synthesise and integrate the many different factors into a unified whole (2.7, 2.9)

- All programmes demonstrate good evidence of a student-centred approach to learning and an emphasis on life-long learning (2.6, 2.7)

- All programmes demonstrate a variety of teaching methods and variety of assessment methods (2.6, 2.7)

CHAPTER 3

THE ASSESSMENT OF COMPETENCE

3.1 Introduction

Whilst it would seem from the analysis of curriculum documents that institutions have a general agreement about the role of the midwife and philosophy of midwifery care, their assessment schemes show marked variations. These variations in style and format reflect local differences in curriculum organisation, some of which are influenced significantly by the validating higher education institution. The role of the midwife and the boundaries within which she operates are undergoing a considerable evaluation in the wake of *Changing Childbirth* (Department of Health, 1993) and this is further complicated by changes in the structure of the NHS and the organisation of maternity care. Midwifery education is also undergoing change with moves into higher education, diploma and degree level education and shared learning with other disciplines.

In the light of all these factors there is clearly a need for an agreed, comprehensive definition of competence in midwifery. Without such a definition it is not possible to make judgements about the effectiveness of midwifery programmes of education in preparing students to meet the changing needs of childbearing women and society.

3.2 The current situation

The public needs to be assured that those about to become midwife practitioners have developed the right blend of knowledge, skills and attitudes to become competent. Jessop (1991) suggests that professional training frequently fails to make explicit statements as to what professionals should know, understand and be able to do. Where standards or statements are unclear or ambiguous it has been found that student nurses and midwives are assessed according to their ability to "fit in" to the culture of the profession (Melia 1987; Phillips et al 1994; Bluff, study in progress). Lankshear et al (1996) found the concept of competence to be still underdeveloped although it would appear professional bodies offer some assistance. The professional bodies for midwifery offer some assistance in determining national standards. The ENB Regulations and Guidelines for the Approval of Institutions and Courses (ENB 1996, 6.4) describes competence as "the ability to perform particular activities to prescribed standards". The responsibility for setting those standards is however left to the approved institutions offering the programme.

To assist institutions develop their assessment strategies, and determine standards for assessment, they are provided with statutory rules. The UKCC Midwives Rule 33 (UKCC 1993) identifies competencies in the form of 'outcomes of programmes of education'. Not everyone finds these to be as helpful as they would like. Whittington and Boore (1988) found that the UKCC competencies (later identified as outcomes) were too general and overlapped with each other in no particular order. Girot (1993) was also concerned about the breadth of UKCC outcomes as their lack of specificity made it difficult to know at what levels students should be assessed. This apparent failure to define clearly what is to count as competence at a particular point is not restricted to midwifery. Eraut (1994b) suggests that a lack of clearly defined standards could have something to do with the ideology of professionalism and rejection of state control. However, as all professions would appear to assess, in some way, the professional competence of their new entrants it seemed pertinent to this study to undertake an exploration of the notion of competence.

3.3 The notion of competence

In trying to move towards a conceptual analysis of competence a review of the literature on competence in education, industry, midwifery and nursing was undertaken (Worth-Butler, Murphy and Fraser 1994 and 1995). This was followed up by an EME Conference where keynote papers by experts in professional education (Eraut 1995) and work-based assessment (Otter 1995) stimulated group discussions (Appendix 6). Emerging from the literature and discussions were two areas which proved to be contentious.

3.3.1 Performance and Capability

One major issue raised in the competence debate is how competence, performance and capability are interrelated. Those in favour of a performance approach to competence believe that performance is capable of "subsuming all definitions of competence" (Further Education Unit 1986). For them, being competent can be inferred through observed successful performance and as such, competence is transparent, observable and measurable (Norris 1991). This notion is based on the assumption that being able to demonstrate the ability to carry out a skill or task implies that the individual carrying it out has the appropriate knowledge and understanding. As such, they believe there is no need to assess knowledge and understanding separately as performance will be unsuccessful without them. Supporters of the performance approach, such as the Unit for the Development of Adult Continuing Education (1989), believe that competence can be measured against a clear set of performance criteria, in specific contexts and at a particular point in time. The performance approach to competence and assessment, according to Hager et al (1994), represents a departure from traditional methods which focused on testing recall and understanding and neglected other levels of comprehension, including application, synthesis and evaluation. The NVQ approach is performance based. However, seeing a potential assessment gap in relying on performance based assessment only, it also allows for the production of supplementary evidence of an individual's ability (Hager et al 1994).

Those critical of the performance approach would argue that being able to perform successfully, even consistently, does not guarantee that an individual knows or understands *how* to perform appropriately in a variety of contexts (Norris 1991). We would extend this 'how' to *why and when*, for in the world of midwifery, carrying out a skill, even successfully, without an understanding of 'why' or 'when' could lead to dangerous practice. Mental ability, cognition and affective reasoning are difficult to encompass in the performance approach. Skills can be acquired through repetition and can be adequately performed to meet the requirements of competence without invoking appropriate mental processes or Benner's (1982) "sensitivity and recognition of situation and variation" to ensure appropriate and effective performance. Equally, being able to perform does not imply that an individual will be committed and motivated at all times to carrying out a skill successfully nor know when and how to perform the skill in a specific context. This concern echoes Southgate's (1994) point about the importance of personal qualities, such as integrity, in competence.

This leads our discussion to the distinction between competence and performance, made by Senior (1976) and Messick (1984). In their view, competence concerns what an individual does under ideal circumstances, whereas performance is what an individual does under real circumstances. Thus competence is about potential and as such is referred to as *Capability* by Eraut and Cole (1993). Capability implies that an individual has the potential to perform consistently successfully and across a variety of contexts. Newble (1992) goes as far as to state that "competence is only of value as a pre-requisite to performance" in the real clinical situation. In this distinction, Eraut and Cole (1993) see performance as demonstrated or inferred behaviour carried out or explained using communication and appropriate technical or professional skills. In contrast, they see capability as that which underpins successful performance and involves:

- knowledge and understanding of key concepts and theory, facts and data, and procedures;
- key personal qualities and attitudes that ensure the general approach that individuals are expected to bring to their professional duties;
- cognitive skills that constitute professional thinking, including analysis, problem solving and assessment of needs.

The concept of capability helps to encapsulate the complexities involved in competence in midwifery bring the notion closer to Gonczi's (1994) idea of competence as integrated intelligent performance.

3.3.2 Competency Development

A second area of debate is concerned with the validity of competence over time. The Unit for the Development of Adult Continuing Education suggests that:

> "Competence is a measure of what someone can do at a particular point in time ... not an indication that a person will continue to be competent or will become more competent". (UDACE 1989)

In this sense competence may be seen as a measure of the expected outcome of initial education or training or as Jessop (1991) implies, the standard required for successful performance. If 'competent' refers to a basic minimum accepted standard then it could be assumed that competence can be surpassed to achieve 'excellence' (Cockerill 1989) or 'proficient' or 'expert' status (Benner 1984). This notion of a continuum is recognised by the UKCC in proposing standards for advanced practitioners (UKCC 1994). Hence competence is viewed by some on a binary scale, that is competent or not competent, whereas others favour a graduated scale from novice to expert.

Eraut (1994b) believes the binary scale, adopted by competency-based systems of training, is "inappropriate for assessing most areas of professional knowledge" and is "incompatible with the notion of lifelong learning" (page 215). This is not to suggest that there cannot be a range of roles and activities deemed necessary for entry to the profession. However Eraut also argues that "it is extremely unlikely that any students will have progressed to the same level of competence right across the range of roles and tasks included in the qualification" (Eraut 1994b, page 168). The problem with this view is that employers might have different assumptions about what to expect from a newly qualified professional. Some professional groups expect to supervise closely and develop their new employees, whereas others such as teachers and midwives will be expected to function without supervision in the classroom or the delivery room. In nursing and midwifery a period of four months preceptorship post-qualification is recommended as good practice (UKCC 1993). This perhaps recognises the need to limit the responsibility given to new practitioners until they have developed considerably more expertise. There could however be a tension between this recommendation for midwives in the UK and the EC Midwives Directive (80/155/EEC) which sets out the activities which each state must permit the midwife (once qualified) to take up and pursue. Newly qualified midwives are entitled to work as independent practitioners. Although they are likely to work with at least one other colleague (Ruegg et al, 1996), this is not the same as having, for example, a period of preceptorship recommended for midwives and nurses in NHS Trusts or the year's probation for new school teachers or the house officer year for medical practitioners.

As, therefore, newly registered midwives are entitled, by statute, to be responsible for the total care of women in normal pregnancy and childbirth, then clearly defining the scope and quality of a midwife's professional competence would seem to be more urgent than that for some other professions. In the light of this, an attempt has been made to try to reach agreement on what student midwives should be able to carry out at the point of registration.

3.4 Towards a model of competence in midwifery

Our research has drawn us to the conclusion that there is no commonly shared definition of a competent midwife at the point of registration. Thus a major challenge for our project has not only been to scrutinise the characteristics of pre-registration midwifery education programmes, but also to develop a model of competence against which to judge them (Worth-Butler, Murphy and Fraser 1994 and 1995).

Midwifery care is described in midwifery curricula as holistic and accordingly midwifery models of competence need to be holistic, integrated and complex in nature. The components of such a model need to be inextricably linked, making it difficult to pull apart for scrutiny without losing or disturbing its integrity. Previous approaches to competence have been criticised (Gonczi 1994) as being atomistic and reductionist because they fragmented competence into a list of tasks or skills with little acknowledgement of the role of underlying knowledge, understanding, personal characteristics and qualities. According to Phillips et al (1996) this approach "may well do violence to the knowledge that encompasses and is expressed in the whole action" (page 2).

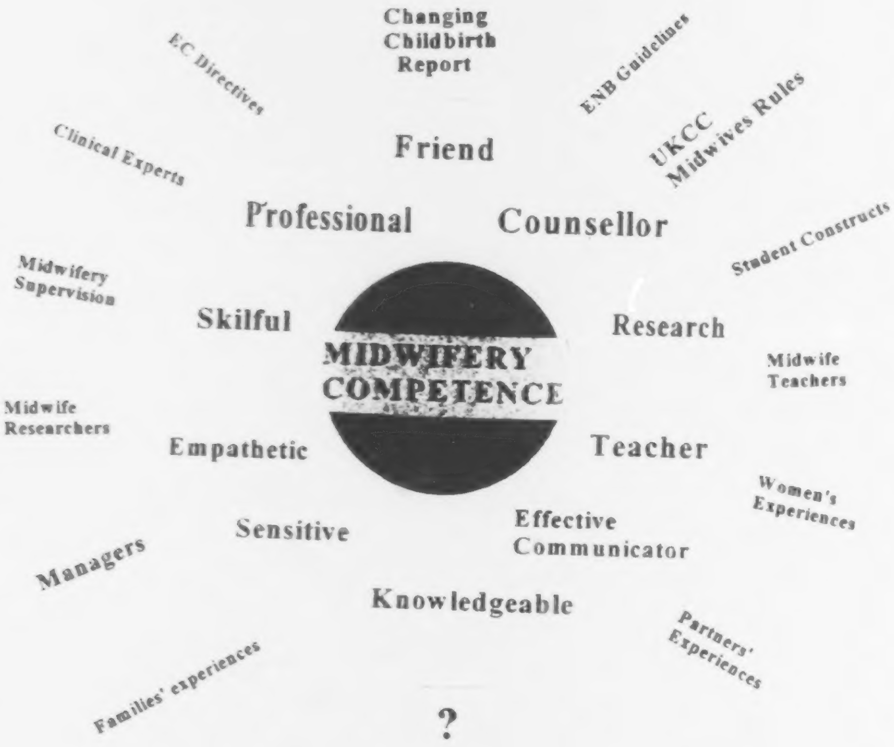
Midwifery has shared with many other professions a healthy scepticism in relation to overt statements of professional competence that can trivialise or compartmentalise what is a complex holistic set of skills and abilities. Nevertheless our understanding of the complexities of professional competencies has moved on a great deal in recent years, and increasingly those involved in professional education (eg Eraut and Cole 1993) are starting to find more acceptable ways of making explicit the characteristics that should be discernible among competent practitioners.

The literature provided a theoretical framework to work with and aspects that need to be taken into account when considering competence in midwifery and how it might be unpacked. The statutory requirements set the scene regarding the boundaries of a midwife's practice and what she might 'do'. Project fieldwork has provided the data to bring the picture to life and to give insight into what this competence means in the reality of midwifery practice.

In order to attempt to make explicit the characteristics that make up the competent midwife practitioner, we canvassed the views of all interested parties, or stakeholders. This included an analysis of documents produced by the Department of Health, UKCC, ENB and what is now the European Union alongside midwifery education curricula. In addition we sought the views of the ENB's Professional Midwifery Advisory Network members, as well as students, midwife teachers and midwife assessors and supervisors in the case study institutions. Work was also carried out to elicit the views of women, their partners and other important members of their families.

Having sought the stakeholders' views and opinions we have been challenged to find ways to reconcile these views (Figure 3.1). Clearly we are not necessarily looking for consensus. There might be quite understandable reasons why different groups value or stress different aspects of the role of the midwife.

Figure 3.1 **Building a model of competence : Sources used**


Changing Childbirth Report
EC Directives
ENB Guidelines
Friend
UKCC Midwives Rules
Clinical Experts
Professional
Counsellor
Student Constructs
Midwifery Supervision
Skilful
MIDWIFERY COMPETENCE
Research
Midwife Teachers
Midwife Researchers
Empathetic
Teacher
Women's Experiences
Sensitive
Effective Communicator
Managers
Knowledgeable
Partners' Experiences
Families' experiences
?

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The midwife is described as a holistic practitioner capable of integrated intuitive performance. According to statute, "She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant" (WHO 1992). Clearly in the role of the midwife, the mother and baby are the focus of care (WHO 1992) (UKCC Code of Practice, Rule 40) (EC Midwives Directive, Article 4) and the midwife's sphere of practice covers various contextual situations and stretches from pre-conception to 28 days post delivery. This role encompasses all aspects of care, including giving information and advice during that time and includes the early detection of abnormality and appropriate action and referral.

The initial literature review of professional competence raised various issues about the very nature of competence itself and what the distinguishing features of a model of such competence might be (Worth-Butler, Fraser and Murphy 1994). One model of professional competence emerged from this review which could be applied to midwifery. Here competence is portrayed as what a person can do under ideal circumstances. It involves:

- being able to select appropriate skills and use them dexterously
- having adequate knowledge and being able to use it appropriately in the delivery of care and
- having caring attitudes, being motivated towards fulfilling a role and towards providing care competently.

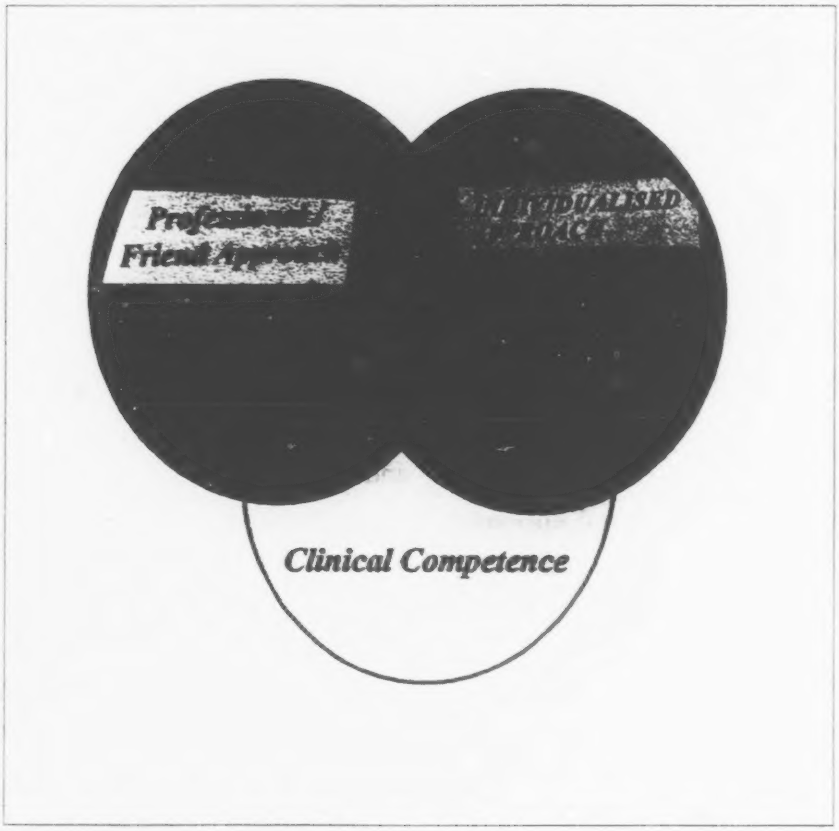
However whilst these capabilities are important for competent practice, midwives are unlikely always to practise in "ideal" circumstances, assuming that "ideal" can be defined. Instead, the suggestions of Hassard et al (1990) and Page (1993) that the components of competence should be intuitively integrated seems better suited for describing the complexity and unpredictability of professional practice. It would appear therefore that a model of competence in midwifery needs to demonstrate the complex integration of all components of competence. That model would need to ensure that competence is durable over time and flexible over contexts implying that practitioners draw upon an overarching set of abilities over a variety of situations to do their job to the satisfaction of women, employers and statute.

A synthesis of data has produced a tentative model of competence in midwifery, (illustrated in Figure 3.2), which over the life of the project has evolved in the light of emerging data and scrutiny from members of the profession.

Although closely interlinked, three main dimensions appear to form the focus for midwifery competence:

(1) the ability to be autonomous and professional but "with woman" **(professional/friend approach)**
(2 the ability to provide individualised care **(individualised approach)**
(3) a sound knowledge base and appropriate skills for the provision of midwifery care **(clinical competence).**

Figure 3.2 DIAGRAM OF A HOLISTIC, INTEGRATED MODEL OF A COMPETENT MIDWIFE


Professional/
Friend Approach
INDIVIDUALISED
APPROACH
Clinical Competence

3.4.1 Professional/Friend Approach

In terms of being autonomous and professional, a midwife is responsible and accountable for her practice as a midwife and must accept responsibility for keeping her skills and knowledge up to date (UKCC Midwives Rule 33). She

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should also be able to take action on her own responsibility including the initiation of the action of other disciplines when assistance is required. As well as initiating the action of other disciplines when required, most of the practitioners interviewed identified the need for newly qualified midwives to be able to recognise their own limitations. They would expect them to be able to provide care unaided to women with normal pregnancies and labours but seek assistance when novel situations arise. Students who fail to seek advice appropriately would not be considered competent, a finding identified by others (Eraut 1994b, Fraser 1994). However alongside this reasonable expectation of students at the point of registration was the need to predict their capability to perform in the future. It was recognised that these newly qualified midwives will need support, as will any newly qualified practitioner. The amount of support actually provided was explored in phase II of the project.

Although midwives need to be autonomous practitioners, they must also be able to function effectively in a multi-professional team. In order to do this they must be able to make decisions, frame and solve problems, be pragmatic, rigorous and diplomatic. Whilst working in a multi-professional team, the midwife must also have the qualities to relate to women as a friend:

> *"... honest ... caring ... sensitive ... friendly ... understanding and empathetic ... " (parents)*

Parents also expect the midwife to be assertive on their behalf and inspire them with confidence. It was thought by some midwives that pre-registration students had an advantage in some respects in that they were not socialised into a sickness model of care and were generally highly motivated and committed to midwifery.

3.4.2 Individualised Approach

In terms of providing individualised care, a midwife must be capable of working in partnership with women and their families. She must have appropriate and effective communication skills, be a good listener seeking and considering parents' views, giving appropriate information for decision making and empowering women to be involved in their own care. Many midwives and teachers saw being an **effective communicator** as being the most important capability of a midwife.

> *".....being able to communicate definitely, you've got to be able to communicate with mothers, partners, families, colleagues, everybody. If you can't communicate then you're a dead loss really on a ward like this. " (Assessor)*

> *"Communication skills. And the ability to listen. I don't mean you know to be able to talk, I think the ability to listen as well is very important, I can't stress that enough really, to be able to listen and to take action on what you feel that particular person is trying to tell you ..." (Assessor)*

She must also be able to be the woman's advocate and have a non-judgemental appreciation of the woman's social, political, cultural, emotional, physical and spiritual background and the influence this has on her experience of pregnancy and the consequences. On the basis of this appreciation, she must be able to assess, plan, implement and evaluate her care with a needs meeting approach. This individualised care ability includes all aspects of midwifery care including teaching and advising women.

> *"...Well, to be competent, to be able to .... competent in practice but be able to actually .... listen and find out what people want, what they want out of the service, what they want out of you, what they want for themselves, for their family and then aim to provide that for*

> *them. And I think you do that by being flexible, by giving them a good midwifery service, trying to achieve ... their aims and what they want. And at the end of it, safe practice, to have a safe mother and baby."* *(Assessor)*

> *"... I think probably the most important capability of a midwife is to be able to see what care is required through the eyes of the women, and what the mother actually requires, and meeting those needs even though they may not be totally in accord with what the midwife thinks the woman wants, as long as it's safe, and I think it's looking at satisfaction from the point of view of the woman rather than satisfaction from the point of view of the midwife". (midwife teacher)*

3.4.3 Clinical Competence

Clinical competence includes skills, knowledge and understanding. There is general agreement that a midwife must have a repertoire of skills which must be used dexterously and appropriately and selection and application relies on an underpinning sound knowledge base and understanding. Knowledge of facts, principles and processes is essential with knowledge of rules, regulations and policies influencing midwifery practice. This knowledge needs to be research-based and constantly updated involving lifelong learning. Whilst knowledge forms the basis for professional decision-making, reflection and evaluation of practice, midwives must also be able to communicate that knowledge at the right level to women.

> *"So, as well as being you know good at practical midwifery and good at research and have a good knowledge, you've got to be able to put it over to the client, and for them to have confidence in you basically. That's what I'm saying". (Assessor)*

3.5 Discussion

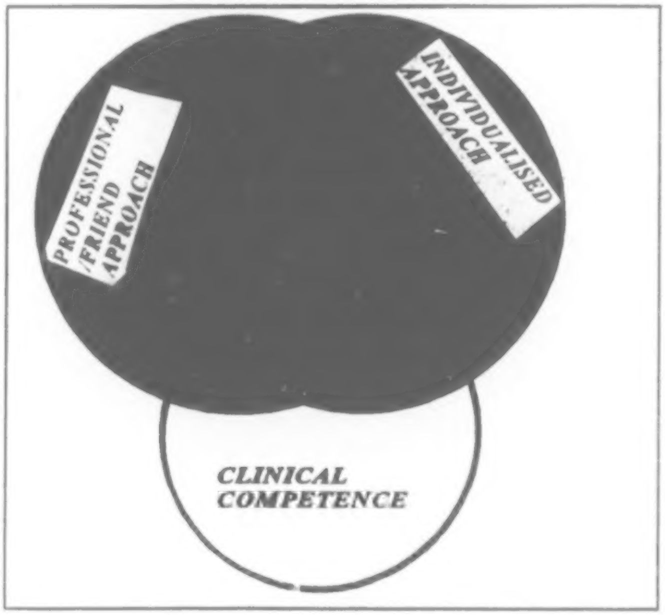
Developing the model has not been an easy task. Data came from a variety of sources but it was difficult to demonstrate the complex relationships that exist between all of the aspects involved. There were some underlying tensions when developing the model such as the risk of losing the holistic concept if competence was to be broken down into components and on this basis it seemed more appropriate to identify dimensions as opposed to producing lists of skills and attributes. The next difficulty surrounded how such a model could be represented on paper.

As can be seen from this tentative model (Figure 3.2), the components of competence in midwifery are interrelated and closely connected. Knowledge, skills and attitudes are perhaps central to the model but cannot stand alone as they require appropriate selection and application to practice. This selection and application requires the professional attributes of responsibility and accountability in taking action which in turn involves the abilities needed to provide individualised care and the inter-personal qualities women expect in a midwife. Many of the issues raised during fieldwork mirror the expectations of practitioners identified in the ENB's Framework for Continuing Professional Education (1991).

An important issue raised in the course of the team's work on competence in midwifery is the role of context and time in competence. In terms of fulfilling the role of the midwife different abilities will be required from situation to situation and a competent midwife will need to be able to transfer her abilities across contexts. In addition, an individual's competence may vary over time. To account for the influence of context and time on competence, this model of midwifery competence is not fixed as there will be movement between the components. One or more dimensions may be more prominent in any given situation or at any particular time. This reflects the role of context in professional competence and the underpinning affective processes that enable a competent individual to cope with differences from situation to situation and from moment to moment within a situation. Two scenarios follow to illustrate how the model accommodates the influences of contexts and time on the three dimensions of competence.

In the first scenario (Figure 3.3), when the midwife first meets with a woman in the antenatal period her ability to develop a relationship with her is of vital importance. From our work with women and from Methven's study (1989) women wanted the midwife to be "friendly" and to treat them like an individual, to make them feel important. They also needed to have confidence that the midwife would at all times be professional in maintaining trust and confidentiality. Hence the professional /friend and individualised approach dimensions are more in evidence than the clinical competence dimension.

Figure 3.3 Professional /Friend and Individualised Approaches are Dominant



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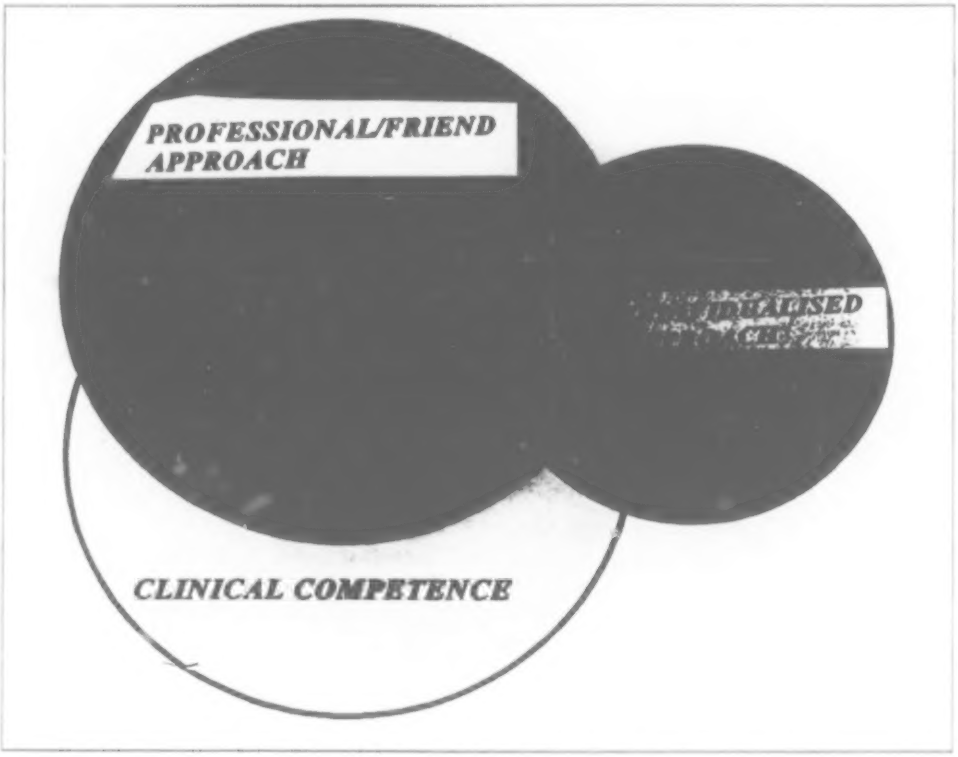
In the second scenario (Figure 3.4), in the emergency situation clinical competence is likely to be the dominant dimension. For example, a woman who has asked for physiological management of third stage of labour starts to bleed profusely following the birth of her baby. The midwife must use her clinical competence and professional judgement to take the appropriate action. Whilst a woman's individual needs are important, safe and expert action and involvement of appropriate others will require the clinical competence and professional/friend dimensions to be most prominent.

Figure 3.4 Professional /Friend and Clinical Competence Dimensions are Dominant



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3.6 Summary

Producing a holistic model of a competent midwife was an essential first step in being able to make judgements about the effectiveness of pre-registration midwifery programmes of education. Account has been taken of the need to acquire skills, underpinned by knowledge and understanding, as well as the cognitive processes involved in making judgements about using the appropriate strategy for each individual in a variety of contexts. Alongside these capabilities students need to develop the personal skills and attributes to be able to hold in tension a reflective and professional approach to work whilst being with the woman as "friend".

This model now forms the framework which we have developed in order to draw together the data collected during this project. This can then be used as a basis for considering the comprehensiveness of institutions' intended assessment strategies and the outcome effectiveness of programmes in preparing students for their role in contemporary midwifery practice.

Key Issues

- A model of competence is needed to provide a framework for assessment (3.2, 3.3)

- A model of competence must be holistic and not atomistic (3.4)

- A model which incorporates three essential interlinked dimensions of competence (3.4) and is flexible according to context could provide a useful framework for a more effective assessment of capability (3.5)

- Midwives should have the potential, personal qualities and capability to perform successfully across three dimensions of competence in midwifery:

  (i) ability to be autonomous and professional but "with woman" (**professional/friend approach**) (3.4.1)

  (ii) ability to provide individualised care which is equitable and appropriate (**individualised approach**) (3.4.2)

  (iii) a sound knowledge base and appropriate skills for contemporary midwifery practice (**clinical competence**) (3.4.3)

- The midwife's professional role is complex, competence must encompass capability across contexts and over time, not merely individual performances (3.5)

CHAPTER 4

BUILDING THE PICTURE

The EME project was commissioned to evaluate the three-year pre-registration midwifery programmes in terms of their outcomes. This contrasts with the Department of Health commissioned project (Kent et al 1993) which concentrated on the process and content of such programmes. However, in addressing the project brief of matching intended with actual outcomes, account had to be taken of the processes which facilitated or inhibited their achievement.

4.1 Matching intended outcomes with actual outcomes

To assess the actual outcomes of the programmes, data was collected during phases one and two of the project. In phase one this included:

- scrutinising student profiles and performance in assessment
- observing the preparation of assessors
- observing end of programme Board of Examiners meetings
- individual interviews with the 39 case study students, their teachers and matched assessors.

The interviews focused on how well students were able to fulfil the role of the midwife at the point of registration, meet programme outcomes and fulfil the outcomes identified in Midwives Rule 33 (UKCC 1993).

During phase two of the project all 39 case study students were followed up into practice. Data collection during this phase consisted of interviews with:

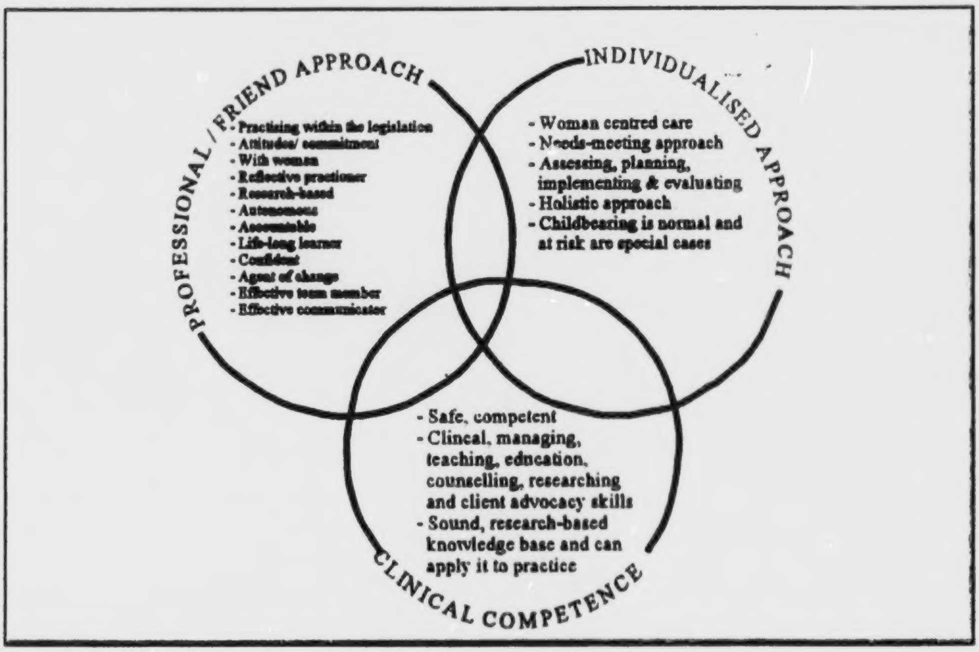
- case study midwives 4 - 6 months into practice

- midwives who had worked with the case study midwives in their first few months
- case study midwives at the end of one year
- supervisors of midwives or managers of case study midwives (in many cases the supervisor was also the manager).

These second phase interviews, set in a more mature practice context, enabled the team to view a variety of stakeholders' reflective judgements on programme outcomes. From these reflections the team was able to identify any gaps in preparation and establish whether such gaps were critical for subsequent effective midwifery practice.

Intended outcomes were outlined in each institution's curriculum documents and were explored during the curriculum analysis in phase one of the project. As stated in Chapter 2, intended outcomes were very similar from institution to institution and all included preparing students to be able to fulfil the outcomes listed in Midwives Rule 33. In the early days of the project, the EME team spent a considerable amount of time exploring the notion of competence in midwifery and collected data from teachers, students, parents and experienced midwives on what attributes were required to be a good or competent midwife. This data, along with data from curriculum documents, helped to build a tentative model of competence which, with continuous refinement and scrutiny, has evolved during the life of the project. It also formed the basis for the development of the assessment matrix outlined in Chapter 10. Figure 4.1 gives an overview of the intended outcomes extracted from curriculum documents. In this diagram, the outcomes are grouped according to the dimension of competence to which they are most closely related. As the model is intended to represent the holistic model of competence, inevitably there will be overlap of outcomes across dimensions.

Figure 4.1 Intended Outcomes Extracted from Curriculum Documents : by dimension of competence


PROFESSIONAL / FRIEND APPROACH
- Practising within the legislation
- Attitudes/ commitment
- With women
- Reflective practioner
- Research-based
- Autonomous
- Accountable
- Life-long learner
- Confident
- Agent of change
- Effective team member
- Effective communicator
INDIVIDUALISED APPROACH
- Woman centred care
- Needs-meeting approach
- Assessing, planning, implementing & evaluating
- Holistic approach
- Childbearing is normal and at risk are special cases
CLINICAL COMPETENCE
- Safe, competent
- Clincal, managing, teaching, education, counselling, researching and client advocacy skills
- Sound, research-based knowledge base and can apply it to practice

This three dimensional model of a competent midwife is used as headings for the following three chapters. It has provided a framework for the synthesis of data and has enabled the team to demonstrate how the programmes prepared students to fulfil their intended outcomes.

4.2 Attrition on programmes

Whilst a study concerned with outcome effectiveness inevitably focuses on those who complete their education programmes, an additional important consideration must be the extent of attrition of students entering the programme. Attrition rates at the six case study sites have been explored and compared with national statistics

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and details of case study attrition are presented in Table 4.1. As is evident from this table, there was considerable variation in attrition rates between institutions with rates ranging from 0 to 45%. Ethical guidelines formulated for the project prevent us from identifying which site has which attrition rate as it could lead to identification of sites. Most attrition occurred in the first year and rates were lower in the second year and lowest in the third year. This finding is replicated nationally (Figure 4.2).

Table 4.1 Overview of attrition /failure rates for cohort

Site	First Year			Second Year			Third Year			Site total attrition
	Failure		Student choice	Failure		Student choice	Failure		Student choice	
	Theory	Practice		Theory	Practice		Theory	Practice		
1	0	0	1	0	0	2 (1*)	0	0	0	3 (2)
2	2	0	6	1	0	0	0	1	1	11
3	4	0	1	0	1	2 (*)	0	0	0	8 (6)
4	0	0	1	0	0	0	0	0	0	1
5	2	0	1	0	1	0	0	0	1	5
6	0	0	0	0	0	0	0	0	0	0
year total %	*19.4*			*7.5*			*3.2*			28 *30.1%*

- The number of students per cohort ranged from 10 to 24.
- Three students * left the programme to go on maternity leave and later transferred to other cohorts to complete the programme.

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Table 4.2

Overall attrition of student midwives entering the programme						
	Cohort		National			
	(EME data)		(ENB data)			
	1991/92		1991/92		1992/93	
Number of students entering	**93**		**255**		**525**	
Reasons	***n***	**%**	***n***	**%**	***n***	**%**
Student choice	13	14.0	56	22.0	79	15.0
Illness	0	0.0	1	0.3	3	0.6
Failure	12	12.9	17	6.7	13	2.4
Transfer	3	3.2	0	0.0	3	0.6
Misconduct	0	0.0	0	0.0	2	0.4
"Other"	0	0.0	0	0.0	2	0.4
Total discontinued	***28***	***30.1***	***74***	***29.0***	***102***	***19.4***
	Cohort		National			
	(EME data)		(ENB data)			
	1991/92		1991/92		1992/93	
Stage of programme	***n***	**%**	***n***	**%**	***n***	**%**
1st year	18	19.4	35	13.7	50	9.5
2nd year	7	7.5	23	9.0	34	6.5
3rd year	3	3.2	16	6.3	18	3.4
Total discontinued	***28***	***30.1***	***74***	***29.0***	***102***	***19.4***

From the interview data, some teachers were very concerned about what they considered to be "high" attrition rates on the programme. These concerns were on the basis of "the investment" involved in the programme and the possible implications of high attrition rates on purchasers' interest in the programme.

> *"and I, I think that I'm going to be asked this afternoon, 'cos I'm going for my contracting meeting, to put the numbers up. And there's a bit of me that says what, how wonderful, they turn out, [it] is tremendous. But the investment, and my manager is saying to me "there's something wrong here you know". Trying to weigh up what is wrong with ... or maybe because the*

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> *group's so small to start with that we have to accept that there will be a higher wastage rate like nursing accepts that there is a higher wastage rate, you know something like 25%." (teacher)*

> *"but all the time I've got this pile of things from Region that says 8% wastage. Well I know the nurses are not meeting that but there's a bit of me that was around obviously before pre-registration and post-registration and of course we didn't have the failures, I suppose it's turning the concept of a failure into a more positive concept. But it's money and they cost money to train. And also whether they don't survive, or whether they survive the first year but they fail. You've turned somebody else away for that place". (teacher)*

Other teachers were concerned at the possible disruptive effect of high attrition on remaining students.

> *"Each time students .... left, certainly the later ones, the group was certainly unsettled by [student 1]'s going, [student 2]'s going, there was sadness". (teacher)*

Various explanations are put forward by teachers for the apparent high numbers of students leaving the programme. These included students not being able to cope with the programme along with family commitments.

> *"..we've lost some students with problems with children. Two left, one after the first year and one after the second year or just into the third year because of child care problems or the stresses of doing the course with a young child. And again I think to do that to have to continually think about child care for three years is a lot because the requirements change". (teacher)*

Comments from teachers also suggested that students coming onto the programme may not have anticipated how difficult it might have been to juggle family commitments with study and full-time work.

> *"..the problems of child care and this has been some of the reasons for the wastage rate, some who struggled through to the third year but once they got*

> *on to rostered service and unsocial hours found that they just couldn't cope with the child minding arrangements and made the decision that at that point they had to give up" (teacher)*

Occasionally, difficulty coping with family commitments further compounded difficulty coping with the academic level required on the programme.

> *"[she] failed and decided that she wasn't going to come back anyway, so she didn't resit, didn't take the opportunity to resit the second time, she'd got two or three other young children, she was finding the course and the family quite difficult to cope with" (teacher)*

Some teachers noted that, in their experiences, three-year pre-registration students had more social problems as students than their shortened course colleagues.

> *"we've had other kind of more personal problems with the pre-reg. More so than the post-reg" (teacher)*

One teacher suggested that if this is the case, it may be because many women attracted to the three-year route may already have child care problems.

> *"[the programme] attracts the more mature entrant and it attracts women who are already in the situation of being single parents who are undoubtedly coming into midwifery but at the same time, have the problems of child care and this has been some of the reasons for the wastage rate" (teacher)*

Our data for these six sites suggests that students are more likely to be discontinued on the basis of theoretical work in the early part of the programme and on the basis of practice towards the end of the programme. Numbers are however too small to be able to generalise and ENB returns from institutions give limited information about reasons for failure. Some teachers felt that students who had been discontinued on the basis of theoretical work would probably have failed on the basis of practice later. Difficulty coping with assessments was mostly due to problems with academic assessment and some teachers felt that this was one of the main reasons students left the programme.

> *"The [programme] didn't evaluate well and we had a high drop out rate. The course was over assessed. I think it still is a bit, but it was badly over assessed. We have still got [a lot of emphasis on exams], we had more emphasis on unseen written exams, and this is what the students failed, the unseen writtens" (teacher)*

> *"[The] first year's examinations where they have to do three papers. I think that's a problem, even though there is help to get over it" (teacher)*

Teachers, students and midwives also cited students who were discontinued on the basis of theoretical work who, in their opinion, would have made excellent midwives.

> *"but it's that terminal exam that they just can't jump that hurdle. I think there were 2 that had gone out on it that who you could argue should be practising because they were competent in practice" (teacher)*

> *"you know people left because they didn't pass the exam and I think some of the people, well a couple of people in particular I think they would have been fine midwives" (student midwife)*

> *"...but certainly one of the hospitals where we've discontinued students that they [midwives] have seen them as good practitioners, ... [they] feel that our emphasis is too much on academia and that we're losing what could be good practitioners" (teacher)*

While students generally disliked exams, they found having exams early in the first year useful for them to learn what was required of them on the programme. Many felt it was better to be discontinued at this stage rather than later when they had invested so much more in the programme. Most students who were discontinued on the programme were discontinued during the first year.

Another issue raised by teachers was the difficulty involved in selecting students for the programme.

> *"My problem is in the selection of them. Even [...] years down the line when I'm faced with somebody sitting opposite me in the chair who - is like a blank*

> *sheet of paper, I cannot see, even though we've got criteria. I mean we've tried everything, what have you, you go on your gut feeling and you still can be wrong. Now I can't legislate against somebody having really monumental personal problems and having to drop out of the course, but what also worries me is the academic failures because they do have, well I think they have, tremendous support from the teachers. Whilst appreciating yet that they are studying at different levels and that we cannot write papers for them." (teacher)*

Predicting a candidate's suitability for the programme was not only a problem for selectors but also for prospective students. Some students had unreal expectations of the role of the midwife or the programme or had little insight into the reality of life as a student midwife.

> *"Some of the students went on their own volition because they realised it wasn't right for them. And I think that takes a lot of courage. I have worked with students, with 18 month students, who've said well I hate it but I'm not going to give up you know because they've started the qualification, but to do that for three years it's different than doing it for 18 months" (teacher)*

> *"The other problem I think is in them identifying that it isn't for them. Because now with their early contact with the client group and the community we've had at least two of them tell us that she enjoyed the study, she enjoyed the kind of academic rigour but didn't enjoy the, if you like the intimate, the intricate relationships that you have to form with women you know. It wasn't quite what she expected. So how do you tell that at interview?" (teacher)*

> *"... [It] doesn't matter how much you tell people how hard it is to do a course, they don't really take it on board. And we did lose a few at the written summative assessments, but I mean that's what they're there for. But you know if you're going to have summative assessments, you're going to have to expect that some students are going to go" (teacher)*

Efforts made by teachers to address this issue had not been very successful:

> *"We do try very hard to put the reality of the course at open days and*

> *interviews. There are the normal sort of problems, not everyone comes to the open days, time is limited for this sort of in depth discussion on interview days and anyway they always think they're going to manage. They can't perceive how the problems are going to worsen over the three years of the course and they're sure they're going to manage. Yeah, it's one of our big areas that are difficult" (teacher)*

There were teachers who were disappointed with the academic success rate of students who had been specifically recruited on apparent academic ability.

> *"Theoretically, they're a disappointment really because we've taken people we think are academically able, but they've struggled to meet the academic requirements. ... we have discontinued quite a few students really .. on academic grounds" (teacher)*

On one site, negative attitudes and organisational difficulties that students working at one placement site had experienced were put forward as possibly being related to higher attrition rates at that particular site.

> *"...and they have had an awful time with the [assessors] at [......] and that's been where our main problems have been. It's where we've had our largest attrition rate, and I don't know if that's got anything to do with it or not" (teacher)*

In Table 4.2 the 30% attrition in the six case study sites is very similar to the national attrition of 29% in 1991/92. However by 1992/93 it is noticeable that attrition nationally fell to 19%. This change in the national situation may in part be explained by the fact that most institutions had their first intakes of three-year pre-registration midwifery students in 1991/92, whereas the ENB figures for 1992/93 include larger numbers of students from more second and some third cohorts. Similarly, most case study sites are in fact now reporting lower attrition rates.

4.3 Summary

This chapter outlines the strategy used by EME team to evaluate three year pre-registration midwifery programme outcomes. Curriculum documents were the main source of data in terms of "intended" outcomes. These have been analysed according to the three dimensions of competence of the model of competence developed by the EME team and this approach was used in our analysis of actual outcomes. The "actual" outcomes, with which a comparison was to be made, were explored through field work at the case study sites. This chapter sets the scene for Chapters 5, 6 and 7, where actual outcomes are explored in depth, and for Chapter 8 which explores outcomes in terms of the needs of newly qualified midwives during their first year as practitioners. The attrition data is particularly relevant when considering the vignettes presented in Chapter 9.

Attrition on programmes is another important consideration in terms of programme outcomes. Our exploration of attrition in the six case study sites showed the following trends, some of which have been supported in data on national attrition statistics held by the ENB:

- Student attrition is most likely in the first year, less likely in the second year and least likely in the third year
- Most students who chose leave the course did so because they have difficulty coping with family commitments
- Teachers were concerned about the perceived high attrition rate
- Teachers outlined the difficulties involved in selecting suitable candidates and in terms of enabling prospective students to anticipate the demands of the programme.

Key Issues

- Curriculum intended outcomes are similar from institution to institution (4.1)
- Curriculum intended outcomes are congruent with the tentative model of competence developed in Chapter 3 (Figure 4.1)
- Attrition is highest in the first year and lowest in the third year (4.2)
- Many students who chose to leave the course did so because they had difficulty coping with family commitments (4.2)
- Teachers identified that there were recruitment and selection difficulties particularly in terms of enabling candidates to anticipate the demands of the programme (4.2)

CHAPTER 5

THE PROFESSIONAL/FRIEND APPROACH

5.1 Fulfilling the statutory requirements for midwives

One of the main requirements of any pre-registration midwifery education programme is to ensure students fulfil the statutory requirements to register as a midwife. An overview of these is therefore presented initially but aspects of them are drawn upon in more detail in later sections.

The UKCC's Midwives Rule 33 was included in the intended programme outcomes for all of the programmes. The UKCC is the statutory body regulating the registration of midwives in the UK and Rule 33 outlines the "outcomes of programmes of education leading to admission to part 10 of the register". In terms of Rule 33, data from interviews with teachers, experienced midwives and supervisors of midwives suggests that the study midwives were able to fulfil well most of the requirements at the point of registration. In half of the cases, assessment criteria were based around outcomes (i) to (xi) and as such, when some assessors in these institutions were asked how well students could fulfil each outcome, they felt they could be confident that students were able to fulfil the outcomes, since as assessors they were required to assess students directly in the clinical area on each outcome.

Typical assessor comments included the following:

> *"........... I think she can fulfil it. We've gone over it and over it and over it. I think she can. I, I've taught her from day one to do this and I think she can, she's capable" (assessor).*

> *"let me just read through them all quickly. .....yes, because it's*

> *almost word for word isn't it in the document? ..... I'm pretty sure [that she can fulfil] all of those outcomes, yes, she'll be able to meet them" (assessor).*

The UKCC requires programmes to be designed to prepare students to assume the responsibilities and accountability for practice as a midwife. From student interviews, it appeared that students, at registration, were very aware that they would be accountable and responsible as midwives once they qualified and many talked about the anxiety which this change in status engendered in them.

> *"I mean this [coming up to registration with exams out of the way] is a very nice period actually because we're considered nearly there but at the same time we've still got a mentor [assessor] there to carry the can as it were, but always in the back of my mind it's you know just a few more weeks now until I'm going to be the one responsible for this situation .. so it's quite, the responsibility is, is quite a frightening prospect" (student midwife)*

> *"Well I still enjoy the job although I am aware that once I start practising as a midwife there won't be quite so much support and you're obviously taking full responsibility for what you're doing which is a bit daunting" (student midwife)*

At the point of registration, there is evidence from midwives, supervisors of midwives, managers and the study midwives that some qualifiers had difficulty taking on full responsibility and coping with being fully accountable. Although students were said by teachers to have achieved all of the outcomes in Rule 33, and "as being competent in all those areas", there was no evidence that students had been assessed as able to assume the responsibilities and accountability for practice as midwives. Instead assessment profiles generally only provided evidence of achieving outcomes (i) to (xi). Becoming accountable and responsible emerged as an important issue and is covered in more detail later in this chapter.

The UKCC Rule 33 (3c) requires a midwife to be able to "accept responsibility for her personal professional development". According to interviewees working with them, study midwives had the skills and commitment required to keep practice up to date as life-long learners and were developing as reflective practitioners. They were equipped with a broad and deep knowledge base for midwifery which was research-based and they had all of the basic skills required for normal midwifery care.

> *"... I think because of the kind of person that she is, she's developed very well. And as I said she'll, she'll push herself forward to be able to increase her skills and her knowledge. So she .. because of the way she is, you don't need to push her, she does that herself. So she has actually developed very well" (supervisor of midwives).*

> *"...and she certainly seems to analyse her practice to the extent that she knows what she needs to develop" (supervisor of midwives).*

> *"I think she's got the right attitude. She wants to do it and she wants to increase her knowledge and her skills and get better at everything she's doing all the time" (assessor).*

Outcomes (i) to (xi) of Rule 33 (3c) list the areas of practice that students are required to be able to fulfil at registration and are outlined below in Figure 5.1

Students appeared to have been generally well prepared to fulfil outcomes (i) to (ix), and where problems were highlighted by assessors and experienced midwives, they related to lack of confidence to take action on their own responsibility and to take appropriate action when deviations from normal were detected. Whilst not typical of the majority, the following illustrates one particular problem:

> *"Perhaps that one ... the ability to take action on her own responsibility including the initiation of action of other disciplines and to seek assistance when required, although she seeks assistance ...she's been inclined to take a back seat taking responsibility, and always behaved like a junior student instead of behaving like a midwife and I think that made it quite difficult, I've had to really push her quite hard to be a decision maker and a thinking midwife" (assessor).*

In relation to two study midwives, assessors and study midwives talked about difficulty that they had when documenting care plans and being assertive when dealing with doctors and other team members. Assessors felt students in general had limited experience of outcome (x), which refers to ethical issues in midwifery, and outcome (xi) which relates to delegation of duties to other staff, though some assessors believed it was not appropriate to expect midwives to be able to fulfil these outcomes at the point of registration. Other assessors were reasonably sure

Figure 5.1

UKCC rule 33, 3c Outcomes (i) to (xi)

(i) the appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health;

(ii) the recognition of common factors which contribute to, and those which adversely affect, the physical, emotional and social well-being of the mother and baby, and the taking of appropriate action;

(iii) the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family;

(iv) the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and to seek assistance when required;

(v) the ability to interpret and undertake care prescribed by a registered medical practitioner;

(vi) the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines;

(vii) the use of relevant literature and research to inform the practice of midwifery;

(viii) the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team;

(ix) an understanding of the requirements of legislation relevant to the practice of midwifery;

(x) an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice;

(xi) the assignment of the midwife of appropriate duties to others and the supervision and monitoring of such assigned duties

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that study midwives would be able to fulfil these two outcomes even though they had not seen them in such situations.

> *"The ethical issues... I mean I can only say again that then again she seemed to understand and we had a good, good talk about things or ethical reasoning or ..." (assessor)*

Some assessors reported difficulties in assessing particular outcomes.

> *"I'm not so sure about the eleventh. I think she's probably still quite, too, too junior to actually be able to handle that. But that will come, I know it will" (assessor)*

> *"... early on I used to put "Not Applicable" for that one because I used to feel that there wasn't anybody that she was going to be asking to do other things. She should be getting on with it herself" (assessor)*

5.2 Midwives' commitment to providing the highest possible standard of woman-centred care

The commitment and enthusiasm of the case study midwives both as students and during their first year in practice was highlighted by many midwives, teachers, assessors, managers and supervisors of midwives.

> *"I think she's she's very competent, and very enthusiastic, willing to learn, willing to be supervised as well, if not sure of something very happy to ask about it" (assessor)*

> *"And she's very enthusiastic you see and I think you know she's very keen to just get on and help and do the best she can and she'd make the best of every situation. She feeds back to us with you know information from the radical midwife meetings she goes to quite frequently .... She's very, very keen in every area. She's an asset to*

> *the team, she's really good" (Manager)*

> *"I think the commitment and motivation to midwifery is incredible, they really desperately want to be midwives, they have an incredible motivation and incredible caring about what they are wanting to do, they after all came into the profession, it was their chosen profession, it wasn't a case of them getting an extra qualification and that really really shows through in the commitment to what they want to do" (teacher)*

At the point of registration, many assessors found new midwives to be more midwifery orientated than previous groups of midwives and lacking the usual "nursing hang-ups". Teachers in particular felt study midwives had both a very strong identity with midwifery, and were very committed to the midwifery profession and to developing as midwives.

When interviewed as students, many participants highlighted the level of commitment needed to be a good midwife, especially in terms of keeping up to date with research-based practice.

> *"I think midwifery's the sort of profession where you just have to be committed to it really, just committed to saying I want to give every woman I look after the best care that I can. She's a woman ... she's a woman in her own right, she's an individual, her baby's an individual and I'm going to give what I hope ... that woman needs ... you just can't go from work from 7.30 to 3.30 every day, go home and forget about it" (student)*

This need for professionals to be able to care not only competently, but also to want to and be committed to caring competently is highlighted elsewhere by Southgate (1994).

According to the majority of assessors, midwives, supervisors of midwives and managers, the programme appeared to provide midwives with the full range of basic midwifery skills and a good knowledge base which they were committed to building upon and developing. In comparison with midwives prepared by old style shortened programmes, midwives and supervisors found study midwives to be more analytical and having a higher level of knowledge, to be able to reason better.

> *"I'm very excited about it in a lot of ways in the theoretical part of it, I'm very excited about that because ...... you can reason things with them at a different level, and......theoretical knowledge is not as narrow, which I think it's a good thing, you know and they do a lot of research really" (supervisor of midwives)*

Data from all sources referred to study midwives' ability to provide a high standard of care and one with which many interviewees would be very happy.

> *"She's a very caring, thoughtful midwife .... The women like her, because she's very caring. And she's got like a very high, high standard of practice" (midwife)*
>
> *"I've spoken to patients who she looked after, who absolutely adored her and felt she was wonderful and I don't doubt for one minute that she was any other than that ... Her team leader ... thought very highly of her work" (supervisor)*
>
> *"I would have any of them look after me very happily and with no qualms... I know they're competent and I know they're confident and I know that they think through what they're going to do ... But I know what their attitudes are and I've listened to them discuss things .... and I know how they think and I know how they do relate the theory to the practice and how they want to use their research" (teacher)*

Having adequate knowledge and skills for high standard care is covered in more detail in Chapter 7, which deals with *Clinical Competence.*

It was clear that for some entrants onto the programme, becoming a midwife has been a long-term ambition and for most this enthusiasm appears to have remained throughout the programme. While some midwives, who may have been a little idealistic in their views of midwifery and being a midwife when they first entered the programme, found the initial period following qualification difficult, only three midwives felt that their first experiences of being a qualified midwife had not met with their expectations. For the majority of study midwives, their expectations had been met or exceeded. However, by the end of the first year, four other midwives had reported feelings of disillusionment towards midwifery.

> *"When I trained Changing Childbirth was coming in, and Changing Childbirth was what I cut my teeth on, I trained on Changing Childbirth and I knew it inside out, and there's no way you can practise Changing Childbirth at (.....) And I find that difficult, ... I think it's just the whole structure. Because it's old school so to speak, you know it's something that's been there for ages, it's very difficult as a pre-registered midwife to come in and see why things are being done, you know I say well why can't I do that, and they said "Well because you don't, you always go to (.....) first", I said "Well why?", "Oh because that's, because we do", you know it's that sort of thing." (study midwife)*

5.3 Midwives as effective communicators

When interviewed at the point of registration, most students said that being an effective communicator was vital to being a good midwife. In their views, it was vital to being both a "professional" and a "friend". Midwives had to be able to communicate with their colleagues to pass on information, to discuss plans and ask for advice, to share knowledge and support, to refer women to their care and to meet legal requirements, for example record keeping. Midwives had to be able to communicate with women in their care, to listen and to give information in order to facilitate informed choice, and to ensure a quality of care that women would remember positively rather than just the minimum standard. It was not enough for a midwife to have the right attitudes and personal qualities but these had to be demonstrated through communication styles. In this way midwives could show that they were approachable and interested in the women, could put women at ease and gain their trust and co-operation. Midwives also needed to be flexible communicators so that they could communicate to "anyone who came through that door" and could give over information at the appropriate level for each individual.

Assessors, managers, midwives and supervisors of midwives talked about most study midwives as good communicators with women, other midwives and other members of the team, of them being able to communicate "on a variety of levels" - "as a fellow professional" or talking to a woman with "very limited English plus very limited knowledge about her bodily functions" and treating people as individuals in terms of communication needs.

They talked about them "making time for women", being "good listeners" and being articulate. For some this developed even more during the first year with "some experience to back up" discussions, "confidence" and reflection on their ability to communicate.

Where there were students described as having gaps in communication ability at registration (only 3 out of 39), this was usually because of lack of confidence or assertiveness and improved with experience.

5.4 Midwives with appropriate, flexible attitudes to care

Several respondents suggested that personality may have a very important part to play in competence or at least with how others perceive a student's competence; and how new midwives were likely to "cope" with their role.

> *"I think it's a lot down with personality as well isn't it? because if someone's very enthusiastic and keen that ..... makes them .... prepared for where they're going in a lot of respects" (assessor)*

> *"I mean we had one girl who I worked with who was ... completely different. I mean I don't know if it all boils down to personality, this girl was .. very dynamic, oozing with confidence, has never had a problem from the day she was a student to the day she was qualified ... I think a lot will depend on selection as well you know" (midwife)*

> *"Again, how much is the actual training ... and how much of it is personality ... it was difficult because she is older than the rest ... you can try so hard that, because you don't want to be made to look a fool particularly, or be a failure, and sometimes I think she's just trying so hard that it came unstuck" (supervisor of midwives)*

Most new midwives were described by assessors, midwives, managers and supervisors of midwives in very positive terms such as - “radical”, “motivated”, “enthusiastic”, “committed”, “self-aware”, “commonsense”, “conscientious”, “nice”, “gentle”, “efficient”, and “professional”. Interviewees suggested that the programme prepared midwives with the right attitudes for care that is women-centred, individualised and holistic. They also felt that study midwives had the right attitudes towards midwifery as a profession and some interviewees suggested that new practitioners with such attitudes could only be “good for the profession”.

> *"....but they're very different I think in their attitude. I think they're more assertive in some ways ... they're certainly more questioning ..." (Supervisor of midwives)*

> *"I think that's the way forward for midwifery, to raise the profile of it as a profession and to get better practitioners really, more reflective and forward thinking and research orientated." (teacher)*

Negative comments about the personal qualities of study midwives were few and far between and focused on immaturity, not being interested, not admitting to shortcomings and seeking advice, anxiety, lack of diplomacy, and not being realistic.

5.5 Working effectively as a team member

Some midwives, assessors, managers and supervisors of midwives commented that study midwives did not appear to be socialised into the "culture" of the National Health Service. While some felt this was perhaps a disadvantage, others noted, in particular, that because they had not been socialised into an "hierarchical system", they appeared to see themselves on an equal level with other members of the multi-professional team. They were quite assertive when discussing issues with doctors or when challenging them if they were unsure about prescribed care.

> *"They're a lot more challenging to teach, I put this down ... they challenge procedures, ways of doing things and they could stop and think about what they're doing, which is very refreshing" (teacher)*

> *"The pre-registration qualifiers are very much more assertive, they are they are more sure of themselves, and they're prepared to make a stand about what they feel is right" (teacher)*

Study midwives themselves appeared to be aware of the need to work effectively as a team member and some felt they had developed as team members, particularly in terms of being assertive and contributing within the team, in the first six months following qualification.

Clinicians and managers interviewed noticed that only when new midwives became confident did they really begin to put forward ideas within the team.

> *"They've all settled down and they've all sort of become part of the team and in actual fact I'm quite proud of them now" (manager)*

> *"Because she's more confident she's now, giving me ideas of suggestions within the team which I think is very good, which you expect you know, I expected that anyway but not initially and in fact six months later here ..... she's obviously developed and she's feeling confident within the team" (midwife)*

Study midwives said they had received a lot of support from the team during the first year in practice and team members felt it was important that they should not be afraid to ask them for advice and support. Even early on, interviewees suggested they were able to contribute to the team in terms of sharing knowledge and stimulating interest in research with other midwives.

5.6 Midwives as reflective and analytical practitioners

When interviewed at the point of registration, study midwives believed that being able to reflect on the effectiveness of their practice and identify learning needs was very important to being a good midwife. Reflective diaries were used in some centres to encourage reflection on practice and there is evidence that some midwives continued to use diaries after qualification. Study midwives also talked about trying to develop their own style of practice not only by reflecting on the effectiveness of their own practice, but also by evaluating the effectiveness of the practice of other practitioners and integrating examples of what they deemed to be good practice into their own.

> *"I think [reflection]'s very important and in fact I do it with some of my colleagues, it tends to be socially rather than you know as part of the work place, but I do like to think back on things and you know how would I do this different or, you know what would have happened if I'd done this instead or whatever, and I do think that's very important" (study midwife)*

> *".... and postnatal, I try to follow them up so I could ask them about the labour, you know if there was anything you could have changed*

> *.... thinking about myself and what .. could I have done different to make this woman's care a bit different ... and sometimes make notes on it and sort of put it in the portfolio ...* " *(study midwife)*

> "*.. It took her a few months to settle down and start practising in a way that she felt comfortable with ... she was looking at taking the best out of her peer midwives' practices*" *(midwife)*

Evidence of reflection was supported by midwives, managers and supervisors of midwives, who when asked about professional development during the first year in practice, had been particularly impressed by study midwives, in terms of development and their ability to identify their own learning needs through reflection. In most cases the views of study midwives about their learning needs during the year were consistent with those of their colleagues, managers and supervisors of midwives.

Many experienced colleagues noted that study midwives were more questioning and encouraged others to question also. In addition, study midwives appeared to be aware of the role of the supervisor of midwives and prepared to use the supervisory "network" to reflect on abilities and to plan to meet learning needs. This finding should be encouraging to some supervisors of midwives who felt that midwives in the past did not make the best use of them to aid professional and personal development and to help with appraisal.

5.7 Midwives as continuous, lifelong learners

Study midwives reported becoming aware, upon qualification, of how much they did not know and being able to see gaps in their abilities. There is evidence in the data of them reflecting on their own ability to provide good care. Students also talked about a different type of learning after qualification to that during the programme, with a greater emphasis on use of theory in practice and integration of the parts into the whole role of the midwife. At this stage of learning 'things were beginning to fall into place' and reports are suggestive of consolidation and midwives becoming more confident in their own abilities. Study midwives felt there were some things which could not be learned until 'they were able to stand on their own two feet'.

> *"Well I think I've really learnt a lot in the last few (laugh) ... you know it comes home to you once you qualify how much you don't know" (Study midwife)*

> *"I feel as though I've learnt a hell of a lot in the last 12 months, you know from what I learned in three years really, I feel that I you know took it in a lot easier ... [as a student] I was pressured into learning at the time in the classroom thinking oh I've got to revise this and just trying to get it into your head without actually thinking about what it is you're learning but that might just be me the way I learn, I learn better by doing rather than reading, you know so but I sort of seen things and then gone back and just read up on them quickly, but I think it as you say it's gone quite quick and I've enjoyed it really, I feel a lot better this year" (study midwife)*

While pre-registration midwives were clearly very capable of identifying their own needs, some felt they had to be quite assertive in the first year in order to meet their learning needs and that a certain level of maturity and commitment to moving on and consolidating practice appeared to be required. Study midwives felt they needed the support of team leaders and managers during the year in order to meet their learning needs.

5.8 Midwives supporting practice with sound and up-to-date research-based knowledge

The data suggests that three-year pre-registration midwives had a good knowledge of current research and were very orientated towards research-based practice, perhaps more so than other midwives. However, it was suggested that at registration they were lacking experience in applying research findings to practice.

> *"I mean she would go away and she would come back the next, next night and she'd read it and .. and that was great because you get a buzz out of that and that's what I meant earlier when I said it challenges you. I think they're more geared, you do think more analytically than the post-registration students, definitely" (assessor)*

In some cases new midwives experienced conflict with other team members due to lack of diplomacy when using research and discussing cases with them. A few study midwives were becoming involved in research projects or thinking about being involved by the end of the first year in practice.

5.9 Midwives as autonomous, accountable and responsible practitioners

This area of the professional/friend approach appears to have been the most difficult for new midwives to cope with. Data from interviews with them at the point of registration showed their awareness of:

- the level of responsibility and accountability required of midwives upon registration
- their interpretations of what it means to be autonomous, accountable and responsible
- individual reactions to and anticipation of being required to take up that responsibility and accountability.

Although none of the teachers interviewed had any doubts that students had been prepared for the role of the midwife, some had reservations about whether students, at the point of registration, would actually be ready to be autonomous practitioners or ready for independent practice.

> *".. I feel that she's probably competent in what she has been exposed to, but I feel that there's still areas that maybe, she, certainly is lacking quite a lot of confidence which is not the same thing as competence, but I feel that does have an effect potentially I think on the way that she'll function as a midwife" (teacher)*
>
> *"... they lack because of the experience and you can never get the ideal but I, whereas I fought very strongly in the beginning thinking that at the point of registration a midwife was a midwife, I now would back down on that and say that I would not like to see a newly qualified pre-reg. midwife be able to go out and practise independently as a midwife. I don't think that they're equipped for it and they need a lot of support for a reasonable period of time, a minimum of six months I would say now" (teacher)*

However, interviewees were confident that this ability would come with increasing confidence and about six months consolidation and that pre-registration students were no different to the shortened programme midwives in this regard.

This intended programme outcome appeared to be the most complex aspect of programme effectiveness and therefore warrants further exploration. Four issues in particular emerged from interviews with midwives, managers and supervisors of midwives six months following registration.

5.9.1 The transition from student to midwife

There is no doubt, from all interviewees, that qualifying involves a difficult step from student to midwife. In the study cohort, about one third of midwives had difficulty with this transition or they were reluctant to take on the responsibility for the role of the midwife or "took a back seat" in decision making. According to interviewees they were not acting like midwives at registration but had remained in the "student mode".

> *"I must admit we just felt they were disastrous, there was not a word for it, the thing is, it wasn't them, but it would appear we were asking them to do what they were not equipped to do. They did not somehow, the transition from being a student to now a midwife, they just didn't seem to, even although they had preceptors, it just didn't seem that that was quite a smooth process" (midwife)*

> *"Well initially when I first started preceptoring her, she didn't have very much confidence at all. She was using me a lot of the time as a mentor rather than ... still in the student mode, not really wanting to take responsibility" (midwife)*

> *"I think my feeling is that she's getting there, she found it very traumatic actually being a midwife and not being a student, and she is improving slowly but she's been slower than I expected. So she is, you know she is definitely improving" (midwife)*

When interviewed at registration, quite a few students said they were "really scared" or "anxious" about being responsible and accountable and midwives commented on them having very low confidence levels or "a real fear of litigation", at first. In most cases, by the end of the six-month period, any problems had been resolved and midwives were acting as expected for junior midwives. However, in just a few cases, although there had been some improvement in confidence since registration, midwives were not as confident to fulfil the role as would be expected. Approximately one third of midwives found the transition difficult but coped well while the another one third of study midwives appeared to have had no problems becoming accountable and responsible. The majority of students interviewed at the point of registration felt they were well prepared for the role of the midwife and were ready to embrace the responsibility involved. Most felt ready to "be" a midwife and some who were anxious to take up a fuller role, had felt restricted by the student role.

> *"I feel more ready now ... to practise. I think the last few weeks have*

> *changed me really, before I didn't think I could ever feel like I'd be a safe practitioner but I feel now that I'm safe and that I'm as ready as I'll ever be to take that step into practice" (student midwife)*

Students talked about a period of confidence building towards the end of the programme where they were preparing to take on the responsibility of the role.

> *"Through the second year you slowly become a bit more confident, but it's only in the third year that I've really felt I've really taken it on like right, now you know this is me, I am the care giver, I have these are my responsibilities and I think that shift was quite difficult" (student midwife)*

There was evidence that some assessors gradually prepared students to take on more responsibility.

> *"At first she was not particularly confident, but as time wore on she became more confident as I gave her more responsibility, I could see that she was taking it on board, like she did give women information, um she did explain what she was going to do before she did it so, on the whole I would say that she ... did get more confident" (assessor)*

Students realised that taking on more responsibility involved becoming more assertive, realising that they would not be expected to know everything and becoming happier to admit when they needed help or advice. Those who felt they had been as prepared for accountability and responsibility as they possibly could have been, talked about how this had been facilitated by increasing responsibility towards the end of the programme.

> *" .... [The] team where I've been working since November and I've been integrated into the team quite an awful lot ... and I've been allowed to be all by myself and to take on caseloads by myself.. .and so the last three or four weeks I have been in a position where it's*

> *been me making decisions here and although initially it's a bit you know, am I making the right decisions, you chunter it over a bit in your mind .... it's been a good experience because we are coming now to the end of the course and we should be able to take on responsibility, there's no point in getting to the qualifying [date] and we're not ready, so ... I've coped alright and I feel really good about it" (student midwife)*

Data from midwives, teachers and supervisors of midwives suggests that an initial "settling in period" of about six months was required after registration within which midwives could consolidate practice to build confidence and begin to feel comfortable with the responsibility of the role and secure within the team. Some interviewees suggested that there was a difference between three-year pre-registration midwives and their shortened programme colleagues in this regard, at registration, but that by the end of six months, most three-year midwives had "caught up". Although all study midwives talk about some level of difficulty upon registration, most coped well and some even took on added responsibility by the end of the first year in terms of counselling, research or teaching. A process of adaptation was described by some study midwives where the sense of responsibility does not diminish over time but midwives do become more comfortable with it and develop strategies to deal with it.

> *"I'm always very very conscious of that level of responsibility ..... think that really is quite a quantum leap really from the last day as a student to the first day as a qualified midwife, so I think that's been a big thing for me. In terms of learning different things I don't think I actually have, it's been a period of sort of consolidation really, of what I've already known . .. but you know .. mentally, living with that shift, you know shift of dimension really that that's been a big thing for me" (study midwife)*

Most of the concerns expressed by students at the end of their programme were centred around the sudden withdrawal of support and having to be ultimately accountable. Interviewees talked about a feeling of having to "let go of the edge and swim" and it appears that the most difficult aspect was actually letting go. Some study midwives suggested that they were not quite ready to take on full responsibility as they had not consolidated their practice or when decisions had to be made previously, a midwife had stepped in. One particularly anxious student seemed overwhelmed by the enormity of responsibility which she would have to take on. Later, study midwives were able to give a retrospective account of their experiences of the transition from student to midwife. Descriptives such as "hell", "traumatic", "horrendous" and "hairy" were used by some study midwives in relation to their initial experiences. For most new midwives these difficulties related to a feeling of "suddenly" being accountable and responsible rather than any other aspect of being able to fulfil the role of the midwife. Being a responsible practitioner felt extremely different to being a student and the transition was more difficult than some had expected.

> *"Well looking back to my first day I think I've developed a lot from, I was terrified!! And when they give me the women to look after the first time they give they only give me three women to look after and I didn't know what to do and I was walking up and down and I thought what am I going to do?" (study midwife)*

> *".. I'm slow but I know that comes with experience because I'm terrified of missing something, and I'm just terrified of the consequences and if I come home and I've delivered a baby right at the end of the shift, I've come home and worried then because I haven't had time to go over everything again! I worry myself sick till I go in the next day ... I used to be terrified of the door bell, and I used to make myself answer the door bell because I was terrified ..." (Study midwife)*

> *"I think the first six months were .. I don't know, suddenly everything seems to be going better now, now the first six months are out of the way" (study midwife)*

This difference in status appeared to be most marked on the delivery suite, especially if midwives felt poorly supported and as though they had been "thrown in the deep end". Being suddenly aware of having to make decisions on their own with little previous experience of decision making and having to make decisions in situations which seemed totally new was a daunting experience. Being responsible for a full caseload when used to caring more on a one-to-one basis was difficult for some who lacked experience organising and prioritising such a workload and managing time. Twelve midwives moved to new units during the first year and, in addition to adapting to their new status, had to settle into that unit and become familiar with different policies, guidelines and support networks. The study midwives who talked most negatively about their experiences of becoming a midwife, talked about an added difficulty of accepting the realities of being a midwife within the current maternity service. Although prepared to provide a certain high standard of individualised care and having practised this type of care as a student with an idealistic semi-caseload, they suddenly realised that it was not possible to deliver this quality of care within the existing service. This was often due to staff shortages and heavy workloads. These study midwives seemed disappointed and frustrated that care seemed so fragmented, felt they were letting the women down and that they had to fight the system if they were to support women.

Experienced midwives, managers and supervisors of midwives were concerned that not all midwives were ready to step into the role of autonomous practitioner as this might place burdens on a team which relied on every member of that team being accountable and responsible. They were however more concerned that new midwives would ask for advice of a more experienced practitioner in any area where they were uncertain.

5.9.2 Possible reasons for new midwives being hesitant to take up accountability and responsibility

Some possible explanations were put forward by midwives and supervisors of midwives who were concerned with the difficulties that some study midwives were having taking on the role of the midwife. Although they felt study midwives had a good grounding in midwifery at registration and had achieved all of their competencies, interviewees felt that as reflective practitioners, study midwives suddenly appeared to realise how much they did not know. This realisation that they still had many more things to learn, instigating a new and very steep learning curve, appeared to compound the sudden realisation that they were expected to be fully responsible and accountable for their actions. Some students in interviews expressed their concerns that they would not know something when required, whereas others seemed more comfortable on the basis that they could not possibly know everything and in any case there would always be someone else there to ask for advice.

There is evidence of a genuine step, in terms of responsibility, from being a student one day and a qualified practitioner the next day, rather than a gradual or phased process. Study midwives felt that their experiences of being a student working within the team involved a different type of responsibility to that of being a qualified midwife. As students, care was based more around the individual with responsibility on a one-to-one basis. Upon qualification, midwives were expected to take on responsibility for a caseload or group of women, often within a busy ward context.

Data from midwives and supervisors of midwives suggests that some study midwives were over-protected or "cocooned" as students and not exposed to responsibility or involved in decision making. Some students felt that assessors had not fully understood the needs of pre-registration students and were reluctant to give them responsibility or to involve them in decision making. When assessors were asked about the preparation that they had had for their role, more than half felt that although they had formal preparation to teach and assess students, they were not specifically prepared to teach three-year pre-registration students or for what should be expected of them. Those who had felt well prepared usually had attended supplementary workshops or more interactive one-to-one sessions with a link tutor. Individual sessions may be more appropriate where midwives have difficulty getting away from the clinical area to attend group preparation sessions.

It was suggested also that differences in individual coping styles and individual personality traits may have contributed to challenges that some participants may have faced in terms of transition from student to midwife. As stated previously, transition was difficult but most students coped and those who coped very well were described by midwives and supervisors of midwives as a "practical common sense individual", "not thrown by situations", "mature", having an "inner calmness". From student interviews, those who appeared to have coped best appeared to have had a considerable amount of insight into and anticipation of what would be involved in terms of accountability and responsibility. At the end of six months in practice, although very capable, a few midwives still had problems dealing with responsibility and decision making.

Many interviewees had observed that three-year programme midwives appeared to have a more difficult transition from student to midwife than shortened programme midwives. However, as mentioned by many, shortened programme midwives had already experienced a similar transition when they qualified as nurses and this experience may have helped them.

5.9.3 Better preparation to take on accountability and responsibility at registration

The data suggests that the programme needs to prepare senior students to anticipate the differences between being a student and being a midwife in terms of accountability and responsibility and to develop possible coping strategies. It suggests that students need to be involved in and to be part of the decision process, and to have some experience of being in charge of a ward prior to qualification. Towards the end of the programme students need to experience the reality of midwifery and being a midwife including taking responsibility on day and night duty. Students need to be allowed to work more on their own towards the end of the programme with assessors taking on more of a preceptor role at this stage. Assessors need better preparation for what to expect of senior students and how much responsibility they can be given.

Some interviewees queried if the programme was long enough or if time could have been better managed during the three years. They felt that study midwives clearly were capable at the point of registration but were not confident or ready to take on the role nor ready to be independent. Post qualification, some still needed to learn to "be" a midwife and some still appeared to need preceptorship and for a longer period than that required by shortened programme midwives.

5.9.4 Support needed at qualification

Initially, study midwives needed a lot of support to cope with taking up full responsibility, being fully accountable. Those who had experienced a drop in confidence at registration needed support to "bounce back". Not all midwives, managers and supervisors of midwives agreed that there were differences in the nature of support needed between three-year and shortened programme midwives. However, some felt there were differences in terms of the length of time support was needed for following registration. While some interviewees felt new midwives should have a preceptor at qualification, some midwives who had been given that option had not taken it up. Where midwives had not been allocated preceptors, other team members tended to plug the gap and study midwives received considerable support from within the team. However, this support was difficult to provide in units where there were staff shortages or where there was a very heavy workload. In some institutions, study midwives had been treated as supernumerary for the first month following qualification and managers were concerned about the cost implications of such decisions.

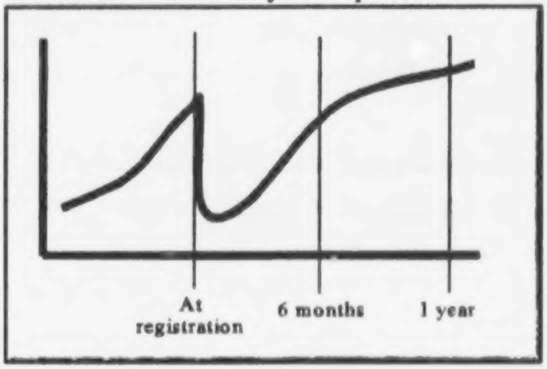
5.10 Confidence to fulfil the role of the midwife at the point of registration

Interviewees appeared to see confidence as a separate entity from competence and although some new midwives were confident, lack of confidence at registration appears to have been the biggest problem highlighted. However, this was also the area highlighted where most development appeared to take place following qualification. According to midwives and supervisors of midwives, once study midwives became more confident, they began to enhance their position within the team, contributing ideas and sharing knowledge. Confidence improved not only in terms of believing in their ability to make decisions and being able to justify them but also in terms of personal confidence. Although more confident, it was important to colleagues that new midwives would be happy to discuss ideas for care with them and ask for advice as needed, and to new midwives that such backup was available to them. This was referred to by many as the "right level of confidence" and in the three cases where midwives appeared over-confident at registration, by the end of six months they had reached the "right level". However this "right level" was described intuitively rather than precise examples being offered.

Confidence seems to have followed a similar pattern for many midwives at registration (illustrated in Figure 5.2), building dramatically during the final months of the programme with students beginning to consolidate their practice and to feel that all of the parts of the role of the midwife were coming together. At this stage some students were given increasing amounts of responsibility and this appeared to be very helpful in terms of confidence building.

Figure 5.2

Confidence in the first year of practice



The majority of midwives experienced a sudden drop in confidence at registration. This may be explained, at least in part, by the shock of suddenly realising that they were fully responsible and accountable for their practice or being thrown by the realisation of how much they did not know although they had passed all assessments and were deemed to be competent. Some felt they had gaps in their clinical abilities and although they had been prepared to give holistic care, until they were competent, with skills such as suturing or topping-up epidurals, they were not equipped to give holistic care. Many experienced a sudden withdrawal of support and felt they had been "thrown in the deep end" especially where the workload on the unit was very heavy. New midwives felt they were least confident on the delivery suite and when dealing with complicated or abnormal cases, the expectations of colleagues influenced their levels of confidence when caring, for example, for women with severe pre-eclampsia. A long gap from qualification to working on the delivery suite increased anxiety.

Following an initial settling in period, it seems, from study midwives and their colleagues, that confidence began to build again. This was aided by the opportunity to consolidate practice, support from colleagues and individual coping strategies. For a minority of study midwives, on the other hand, confidence did not appear to fall but to continue to improve following qualification. These individuals appeared to have considerable insight into the realities of being a midwife and anticipation of what difficulties might be involved.

By the end of the first six months in practice, midwives and supervisors of midwives believed that most study midwives were as confident as any junior midwife. By the end of the first year in practice, most study midwives were said to have needed no more supervision than their peers. At this stage, interviewees said they only needed to have someone available for advice when they were in charge of a ward or when providing care for complicated pregnancies or deliveries.

5.11 Midwives as agents of change

It is difficult at this stage to evaluate study midwives as agents of change. It is clear that study midwives, at registration, were evaluating their own practice and the practice of colleagues and developing individual styles of practice based on these evaluations. As students, some talked about being involved in a changing system of care which was becoming more woman-centred and midwifery-led and most of those who appeared to be happiest as midwives were practising in new style teams or units. As practitioners, some were disillusioned that change has been so slow and they talked about the need to fight the system. They saw themselves as women's advocates and felt they had a role in protecting women from unnecessary intervention (not only from medical staff but also from other midwives). Being an agent of change appeared to bring with it a certain amount of conflict and in order to avoid this conflict, some new midwives admitted to going along with the system, at least until they became more assertive. For others who had tried to stand up for their beliefs in the need for change and to develop their own style of practice, the resulting hardship had coloured their experiences of being a midwife and caused disillusionment. It seems that new midwives needed to become confident before they could feel that they belonged to the team and could become involved in change within the team.

5.12 Summary

This chapter has explored how intended outcomes of three-year pre-registration programmes of midwifery education appear to have been met in terms of preparing midwives to fulfil the *Professional/Friend Approach* dimension of the EME *Holistic, Integrated Model of Competence.* Data on student ability at the point of registration and in the year following from assessors, more experienced midwives, managers and supervisors of midwives provided the basis of our evaluation. Study midwives were portrayed as:

- committed and enthusiastic
- midwifery orientated and woman-centred
- having good personal qualities
- a good research-based body of knowledge
- having good basic midwifery skills;
- being committed to providing high standards of care.

Study midwives saw themselves as part of the multi-professional team and appeared to have developed as effective team members during the year. They were noted as reflective and analytical practitioners and motivated towards lifelong learning. They showed they valued the need for effective communication and felt they were developing confidence and assertiveness as communicators.

Where study midwives had problems in terms of fulfilling the *Professional/Friend*

Approach, these problems usually centred around being (a) less confident and (b) making the transition from student to accountable and responsible practitioner. Most midwives needed a lot of support initially to help them to cope with these two areas. However, some study midwives had "the right level of confidence" at registration and some interviewees felt differences in confidence were also related to the individual personality differences. In order to build confidence, many interviewees felt a period of about six months was needed following qualification where new midwives could consolidate practice. Some interviewees raised suggestions about how the programme could be improved to prepare students more effectively to become confident and to deal with responsibility and accountability. These included:

- giving senior students increasing levels of responsibility towards the end of the programme;
- involving students more in decision making;
- identifying students who lack confidence at an earlier stage in the programme and helping them to become confident;
- preparing mentors better for what to expect of students.

This concept of programmes needing to allow students "to be a midwife", in the context of supported learning, to prepare them for professional autonomy and accountability is not new (Fraser 1993). However, for some case study students it failed to be a reality.

Key Issues

- Midwives qualifying from these programmes were found to be committed to the concept of woman-centred, midwifery care (5.2, 5.4)

- Midwives qualifying from these programmes demonstrated a strong commitment and enthusiasm for contemporary midwifery practice and ongoing personal and professional development (5.2, 5.6, 5.7)

- Communication skills and personality appeared to affect ability to balance the tension between being a "professional" and a "friend" (5.3, 5.4)

- There were some gaps in assessment evidence (5.1, 5.3, 5.9)

- There was sound evidence of good intuitive judgements by teachers and assessors, about student capabilities once practising midwives (5.1, 5.2)

- Assessors and preceptors were not always well enough prepared for their role to give students the right amount of responsibility and guidance (5.9)

- Students who are allowed "to be a midwife" before the end of the programme are more likely to cope well with the transition from student to accountable and responsible practitioner (5.9)

- Transition from student to midwife is difficult and often accompanied by a drop in confidence but this quickly improves (5.1, 5.5, 5.9, 5.10)

CHAPTER 6

THE INDIVIDUALISED APPROACH

This chapter explores student ability at the point of registration in terms of providing individualised care. This involves being able to work in partnership with women, assessing their needs taking all relevant factors into consideration, planning and providing care based on these needs and evaluating how care provided meets women's needs. Providing individualised care also requires midwives to be the woman's advocate where necessary and to be able to provide holistic care. Whilst it could be argued that there is overlap with the special "with woman" or "the woman's friend" aspect of the previous chapter, the emphasis here is different. It has more to do with student abilities to engage in problem design and problem solving (educationally), seeing each woman as an individual with different needs.

6.1 Woman-centred care

The emphasis in programme documents was on preparing students to provide woman-centred care and this approach is one of the main objectives of *Changing Childbirth*:

> *"The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved".* (DoH 1993)

Data from all sources supported the commitment of study midwives to care which is focused not only on the woman but also on her family, and to their ability to provide a high standard of individualised care for a woman with a normal pregnancy.

> *"They are very woman orientated but then that doesn't mean we aren't. ... and they're a little bit more go and get up, go for it sort of thing than perhaps some of us are, if I'm honest.... perhaps they're a little bit more mother orientated and a little bit more sharp with it if you know what I mean" (assessor)*

From interviews with students about the most important qualities of a midwife, it was clear that many felt being able to work in partnership with women was one of the most important aspects of being a good midwife. For them, this involved "looking at the woman as a whole" and "taking note" of all of the "factors" (this implies an "awareness" of possible factors) so that all of her needs are considered and "being flexible" to provide care based on individual needs and choice. The importance of good communication skills in working with women was emphasised, in terms of "the ability to listen well to women"in order to ascertain their needs and to give information so that they can make "informed choices". Lastly, the importance of ensuring that care given is within the bounds of safety while trying to accommodate women's wishes was mentioned by one student.

This data supplied by students suggests that students' philosophy was focused on woman-centred care but data from other colleagues working with them provided evidence that this philosophy was also used in practice. Study midwives were portrayed in terms of taking what the woman wanted and "trying to work with it"; not just being aware of needs but "sympathetic" to them and seeing every woman as an individual as opposed to making broad assumptions about them.

> *"She's a very approachable person, I think she has the ability to meet the needs of the woman, whatever her culture or background.....I have a lot of Asian women in my practice and I think*

> *you have to adjust needs accordingly." (assessor)*

> *".. she was very good, ... with the physical, emotional and social wellbeing of the mums. I think she took every mum as an individual and was able to consider the type of home they lived in and everything from how they were emotionally and how they were coping, the different social situations that we found ourselves in, she was able to adjust to each of those". (assessor)*

6.2 Needs meeting approach

According to most assessors study midwives appeared to have been prepared with a "broader perspective" theoretically, to appreciate the social, political, physical and cultural needs of women. However, in some cases, opportunities for students to experience meeting different cultural and political needs were limited in the population that they cared for. Assessors gave examples of how study midwives made time to sit, listen and discuss issues with women and according to midwives and supervisors of midwives, study midwives developed more as communicators with experience following qualification.

> *".. well I would think during her time, certainly [she] communicates better. She communicated quite well, you know as a student but I certainly feel she's communicated better ..... she's got a lot more confidence now than what she had as a student". (midwife)*

> *"... she's always been able to communicate well, but she now does it with ... experience I think behind what she's actually saying". (supervisor of midwives)*

> *"I think her interpersonal skills in talking to people and talking to the woman and actually communicating with staff has improved considerably". (supervisor of midwives)*

6.3 Assessing, planning, implementing and evaluating care

According to assessors, most students had been given a small caseload to care for and had had experience of assessing, planning, implementing and evaluating care and had shown assessors that they were capable.

> *"... because she had her own patients. We worked together, but she had her own patients, and she prepared the care ....in the morning she prepared the care and she went through it and then if she got stuck on any problems she came back to me and we went through it at the end of the day". (assessor)*
>
> *"yes well I know that she was taught to how to assess, plan, implement and evaluate care, because she did it when she was out with me, and we discussed that, and she was actually able to do it". (assessor)*

However, a minority of students were lacking experience planning and evaluating care and had not been given a caseload (some because they had not passed exams). A few assessors suggested that, although students were well prepared with theoretical input to assess, plan, implement and evaluate care, they were lacking experience using theory in practice.

> *"The ability to assess, plan, implement and evaluate care within the sphere of practice of the midwife and to meet the physical, emotional, social, spiritual and educational needs of the mother, baby and the family. Again she didn't need to do any planning, ... Perhaps I've done it wrong, I don't know." (assessor)*
>
> *"assessing, planning and implementing. I mean, she had to work on that quite hard .....because I think they learn all the theory in school but the actual practical is all done on the wards and it's quite difficult when you have no background at all." (assessor)*

This was one area where assessors felt students would continue to develop as practitioners after qualification. Although some students would be able to assess, plan, implement and evaluate care, they had needed support and guidance to document plans for care, but this too would develop with experience.

> *"...... to evaluate the care within the sphere. I think it's a lot to ask them when they're qualified first. She would be good on her own, and I think with practice she'd be excellent, very, very good." (assessor)*

> *"I mean with the care plans and things I think .. you know obviously she needed a lot of guidance as to how to write things, how to document things and again a lot of that sometimes you know just comes even when you're qualified I think. It's learning and understanding but her documentation and everything's fine". (assessor)*

Data from midwives and supervisors of midwives suggested that study midwives needed support in the first year, from more experienced colleagues, to plan care especially for unusual cases. In addition, study midwives needed support with documentation.

> *"Not the run of the mill things, but sometimes if a baby say developed a feeding problem or an early jaundice, she wouldn't automatically document it as such, so you just have to remind her really just to write it down". (midwife)*

> *"Some documentation as well comes to mind. Whether we do more documentation here than what she's used to doing, but she just needed people to remind her to document problems and things...". (midwife)*

By the end of the first year, supervisors of midwives talked very positively about study midwives' ability to keep records of care given.

> *"I mean I've spoken to her manager who I have to say is very impressed with her, very impressed with her standards of practice, and as supervisors did, we periodically do an audit of record keeping and one of my supervisor colleagues said that her record keeping was picked out as one of the best....and in fact I looked at .... a care plan of her's and .... I have made a comment that her records were very good .... clear and logical." (supervisor of midwives)*

In terms of evaluating the effectiveness of care, a few case study midwives said they valued the opportunity to talk through their care with other colleagues and also with the women they cared for, "as a sort of debrief".

6.4 Midwives as holistic practitioners

Study midwives appeared to want to provide holistic care at registration, "no longer seeing delivery as a task" but part of the whole role of the midwife. However, experiencing holistic care appears to have come very late in the programme. Study midwives described having to run around "catching babies" towards the end of the programme in order to meet the EC requirements for deliveries rather than getting that experience as a part of normal holistic midwifery care. They talked about the need to consolidate at the end of the programme or after qualification, because as students, they had not been able to consolidate earlier. The ability to consolidate appeared to be most important in terms of becoming confident in their ability to fulfil the midwife's role. A few midwives felt they would not be prepared fully for the role of the midwife until they could suture and top up epidurals as they would have to ask someone else to carry out these tasks rather than actually fulfilling the woman's needs themselves.

> *"... The only thing that I'm not too good at yet is suturing which is*

> *something that I, I do want to do but I haven't actually had enough experience yet" (study midwife)*

Assessors, midwives, supervisors of midwives and managers suggested that the majority of study midwives had been well prepared, at registration, to provide care from the first few weeks of pregnancy through to the end of the postnatal period, once everything was normal. However, most study midwives felt least confident providing all aspects of care in labour and felt they would need some support there initially.

6.5 Providing holistic care for a group of women

Assessors, midwives, supervisors of midwives and managers agreed that three-year pre-registration midwives had been prepared well to provide care based on a problem-solving, needs meeting approach and that study midwives' philosophy for practice put women at the centre of care. This is consistent with programme objectives, as outlined in curriculum documents and is consistent with one of the main objectives of *Changing Childbirth.* As students, providing care was based on a holistic approach while caring only for a small number of women at a time. However, there is evidence in the data from all sources that students at the point of registration and as practitioners in the first year were required to switch suddenly to caring for a larger number of women, often within the context of a busy ward. In some sites, clinical areas were very busy due to staff shortages so that new midwives had to take on a much larger workload. Many found it difficult to provide the same standard of care that they had been able to as students and some felt they were "letting women down".

> *"she found it very difficult to see the ward as a whole, she worked very much just looking after individual people rather than seeing the whole ward and how it worked, which we felt was because she'd*

> *never had, she'd always worked as a student, ... I think as providing care for each individual person she had developed well, but she was still finding it very difficult to see the whole picture." (midwife)*
>
> *"it's the individual care she gives is good, but having to cope with not only looking after the women but the demands of ... telephone, doctors' ward rounds and things like that; it's these other things that she finds difficult". (midwife)*
>
> *"you're focused in on the complete care of one individual really, and I think you know, that's the mentality that they come through the tunnel with is that, whatever they do is geared towards one person". (midwife)*

However, a few midwives had had experience of managing a mini-caseload as senior students and midwives working with them felt they could prioritise and manage time at registration. Most midwives developed well during the first six months in terms of organising work, managing time and prioritising and midwives working with them were very impressed at the rate of improvement. In just a few cases, study midwives still had problems prioritising their workload in the second half of that year.

Study midwives saw themselves as advocates and felt they needed to speak up for the woman in their care. In terms of being an advocate, there were those who felt they needed to become more assertive and hoped that this would come with experience post-qualification. For others, trying to cater for women's wishes was the cause of conflict with more experienced members of staff. The issue of safety was raised in focus group work by practitioners who were concerned that in the current philosophy of care with its growing emphasis on choice, midwives should be able to balance women's choices with safe practice. It appeared from the data that supervisors of midwives were wary of new midwives practising autonomously at registration and perhaps they were concerned that they might not be experienced enough to balance women's wishes with safe practice.

> *"[She] is really wonderful you know I mean .. She has radical ideas..... but....of course she needs to gain a little bit more experience on delivery suite, and [her] only fault is that she will not tell us what she's doing, but I don't see that as a fault, she is the patient's advocate, and I think sometimes she's so nervous of the interference .. and being in the junior position, and she really practises from a research base ...... and I have gently said it to her, "you know when you're out there on delivery suite, make sure you just tell who's in charge what is going on in your room" because she could lock away doing her own thing, but she has got the patient's interest at heart". (supervisor of midwives)*

6.6 Seeing pregnancy and childbirth as a natural process

The data suggests that students on the programme were orientated towards health and seeing pregnancy as a natural process and at the end of the programme had a different outlook to that of shortened programme midwives with the care that they gave based around facilitating and supporting rather than the provision of physical care. This is consistent with curriculum "assumptions" that midwifery care is based around normal pregnancy and "high risk" cases are regarded as "special cases" (with a multi-professional approach to care). This apparent change in philosophy was regarded favourably by many interviewees and many students themselves appeared to prefer to be involved in caring for women with normal pregnancies. However, one or two study midwives had been involved in caring for "high risk" women as practitioners and appeared to have enjoyed the experience.

However, because the programme had such an emphasis on the normal, study midwives did not appear to feel ready to provide midwifery care in abnormal or complicated cases at registration. Because they realised they would need assistance with the "high tec" needs of women, students were inclined to feel that care would be fragmented and not individualised. Interviewees agreed that new midwives would need a lot of support in these situations, as would any midwife who was not continually updated to provide care in complicated cases. Of more importance to assessors, midwives, managers and supervisors of midwives was that all (with one exception) could be relied upon to detect deviations from normal, report them and take appropriate action with support. It is possible that the emphasis on normal midwifery had been instrumental in developing these abilities.

6.7 Summary

This chapter explored how three-year pre-registration midwifery programmes of education prepared students to fulfil the *Individualised Approach* dimension of competence. Interview data portrayed the ability of study midwives, at registration and during their first year as practitioners, very positively. There is evidence that study midwives were very committed to a philosophy of care that was woman- centred and that focused on a needs meeting, problem solving approach. Care given on this basis was to a very high standard and feedback from women in their care to colleagues was very complementary about their experiences of care. Study midwives felt very well prepared with an understanding of the factors influencing individual needs and colleagues supported their ability to use this theory in day to day practice. Study midwives appeared to be very orientated towards a system of care that involved assessing, planning, implementing and evaluating care. Although qualifiers had a lot of experience assessing and implementing care, some had limited experience planning and evaluating care. Other study midwives felt they needed more experience and support, initially, when documenting care plans. Study midwives saw themselves as holistic practitioners and were anxious to develop a full range of skills which they felt they would need to provide such care. While the emphasis as students had been on the provision of the full range of holistic care for individuals or small groups of women, following registration, study midwives were required to provide care for much larger groups of women and needed to develop in terms of prioritising and managing time.

Key Issues

- Midwives qualifying from these programmes were found to be committed to a philosophy of care that is woman-centred and which draws upon a problem solving, partnership approach to meeting individual needs (6.1, 6.5)
- Midwives qualifying from these programmes demonstrated understanding of the factors influencing individual needs and the importance of informed choice (6.1)
- Whilst a lot of experience was provided for students to learn to assess and implement care, some had limited experience in planning and evaluating care (6.3)
- Study midwives sometimes experience stress in trying to meet individual needs whilst ensuring equity of care for larger groups of women (6.5)
- Transition from student to midwife revealed some deficits in ability to prioritise and manage time in a busy maternity service (6.5)
- Study midwives were keen to learn any skills not acquired before registration to enable them to be holistic midwife practitioners and avoid fragmenting the woman's midwifery care (6.4)

CHAPTER 7

CLINICAL COMPETENCE

This chapter explores how students were able to fulfil the intended outcomes which relate to the Clinical Competence Dimension. This dimension focuses mainly on knowledge and skills, and being able to apply them appropriately to each practice situation. Data were obtained mainly from in-depth semi-structured interviews and student profiles. In places it has been possible to quote actual numbers of responses because evidence in the field was obtained for all case study students and is therefore meaningful. Elsewhere, as appropriate for qualitative data, it is only possible to describe the issues that emerged in broader terms.

7.1 Midwives who are safe and competent

Assessors, midwives and supervisors of midwives talked about the importance of a midwife being safe and agreed that study midwives, who had all of the basic skills for normal midwifery practice and a good knowledge base, were safe at registration provided they fulfilled three conditions. The first required them to be aware of their own limitations and of the midwife's sphere of practice and to ask for help or advice if they were unsure about anything.

> *"well that we're safe, a safe practitioner, I think is probably the most important one because you know it's it's very nice if we're brilliant communicators or lovely to our patients or you know superb at doing you know getting intact perineums every time but I think the most important thing is that you've got someone who's safe who knows both the basic basic midwifery skills and knows what to do when they don't go right". (assessor)*

> *"..... but as I say I think she's safe and if she's not sure she will ask*

> *and I think that's really essential for all of us you know, no matter how many years experience you've got". (assessor).*

The second condition required midwives to be able to detect deviations from normal and refer these deviations to a more experienced practitioner.

> *"I think she'd be very competent and confident. I think she has the ability to detect when there's any deviation from the normal and she knows how to approach the appropriate authority to sort the problem out, so I'd feel very confident". (supervisor of midwives)*

> *"certainly a woman coming in labour, I'd be quite happy to let her look after and quite sure that if she recognised any abnormalities she'd act on it." (supervisor of midwives)*

The third condition indicating a 'safe' practitioner, which was mentioned less by interviewees than the other two, was that a midwife's practice was research based, and this is covered later in this chapter in more detail.

> *"... she's a competent midwife and could and in fact she's now having her say more ... which I think is pretty good because we need people like that now to say Why are we doing? .... questioning. ... she's using research and I encourage that ....". (supervisor of midwives)*

> *" I think you've always got to continue backing it up with your theory and your research, you know I expect to do that so you know what advice you're giving is safe... it has been researched" (study midwife)*

In relation to the first condition, interviewees emphasised the role of confidence in a newly qualified midwife being able to admit that she did not know something and being willing to ask for help or advice of a more experienced practitioner. It was important that students were confident but not over-confident - referred to as " the right level of confidence". Midwives, assessors and supervisors of midwives suggested that they would consider a midwife who was lacking confidence to be safe before one who was over-confident and might undertake tasks she had not been taught:

> *"I think she will make a good midwife, I do. She's confident without being over-confident. She does know what her limitations are. She's not frightened to ask questions and query things that she doesn't understand, and I think that's essential". (assessor)*
>
> *"She's certainly safe ... she's certainly aware of her own limitations and I think she thinks she has more limitations than she actually does have sometimes, but again that's the confidence. But the competence level is certainly there". (supervisor of midwives)*
>
> *"... when she first started I felt she was over confident ... she's mellowed a bit and she's all right, you know, she's calmed a bit and she's all right now, you know she's .. seen different things on labour ward which has sort of dampened her down and she's doing quite well now". (midwife)*
>
> *"Well I think she's a safe practitioner .... I think she's now becoming more confident....I would say, I wouldn't have any qualms about her as a practitioner whatsoever. I feel she's a safe, good practitioner". (supervisor of midwives)*
>
> *"I'm not quite (sure) ..... I'm hoping she wouldn't take a chance, I'm hoping she wouldn't do because I have sort of said to her ask, seek guidance, because she's that overbounding type of girl that might think that she's doing the right thing and she might be just a bit sort of, a bit too overbounding, so I'm hoping that she would ask for guidance and advice". (midwife)*

By the end of the first six months interviewees were happy that the four midwives who appeared to them to be over-confident at registration would be aware of their limitations and be prepared to ask for help.

In terms of detecting deviations, interviewees were confident that 36 of the 39 study midwives were able to detect deviations from normal. Although the UKCC outcomes require midwives at registration to be able to take appropriate action when deviations are detected, interviewees and focus group participants felt some midwives would need support to take such action and that this need for support was acceptable provided midwives sought advice from a more experienced midwife about referral.

> *"I think she's capable of going in there and looking after a woman safely and competently and making decisions on her own. That isn't a problem. And I've got every confidence in her realising when there is a problem and you know even if it's a matter of just getting advice from somebody who's been in that situation before, a senior midwife. And I've got no doubt that put in the position where she was in doubt or something had been said to her that she would summon senior help, which I think is very good". (supervisor of midwives)*

> *"Even though you think you're ready for it, suddenly you've got that responsibility and yeah, you do need the support and to know that you can just ask anything, that you haven't got to be expected to know everything straightaway". (assessor)*

Study student midwives, themselves, provided evidence in interviews that they were aware of the importance of safe practice and that they knew what was required of them to practise safely:

> *"Well first and foremost she must be safe, to be able to recognise the normal, to have a good understanding of what is normal midwifery and then you can practise safely". (student midwife)*

> *"I think those things are really important ... Safety, making sure that your practice is safe, your accountability, documentation, all those kinds of things has been reinforced over and over again". (student*

> *midwife)*
>
> *"I think she's got to be, before everything else I think she's got to be a safe practitioner because you know however horrible the mother thinks you might have been with her, if the mother's safe and healthy and alive .. she can whinge to her friends and she's not in danger from a bad attitude .. but I think a safe practitioner has got to be the most important". (student midwife)*
>
> *"I think you've got to realise your own limitations and the fact that this course means that you are safe to practise, it doesn't mean that you know everything or can know everything, that is very important, and I have I have realised that, that you can't know everything in three years". (student midwife)*
>
> *"I'm much stronger now in my own views and I'm much more confident to say "I don't think something is right or I don't think that's safe" and I'm much more confident in my own practice". (student midwife)*
>
> *"... I would say generally that for a normal labouring woman I feel fairly competent. Where there's deviations from normal I would say that I can cope with them adequately. I mean I know when to get medical help and things like that, so I would say that generally I'm fairly competent. I mean I'm no expert by any manner of means but I know what I'm doing hopefully". (student)*

Reservations were expressed about three midwives whose profiles are outlined in Chapter 9, in terms of safety. Concerns included that they could not be relied upon to detect deviations from normal and report them and that one could not apply research to practice:

> *".. again this was months before she was taking her finals when you expect people to be ....they are going to be safe practitioner .... and [she] didn't pick up [a wound infection] or she did pick [it] up ... but*

> *didn't report it". (assessor - about student #1)*
>
> *"I feel [she] needed a lot of support when she first came .... I think she felt out of her depth and it was obvious as well.... she unfortunately was put in with a patient to special and she was totally out of her depth and she didn't admit that". (supervisor of midwives - about student #1)*
>
> *"since she qualified, we have had reservations. I feel... I still can't rely on her totally to ... recognise and pick up anything that might be deviating from the norm". (supervisor of midwives - about student #2)*
>
> *"I wouldn't be happy about her practising safely yet on her own, I think she'll need a lot of supervision for a little while ... [she] needed a lot of things pointing out about how for instance low haemoglobin could influence the outcome of a labour in as much as she might bleed or not and how she may be feel ... the mother may be feeling in herself, and the healing process is afterwards. There were all sorts of things like that, that you couldn't put into practice really .... I think she needed some help there in translating research to the use in practice really. Sometimes she didn't come up with things like other students have done." (assessor - about student #3)*

The following sections deal with safety and competence in terms of midwives having appropriate knowledge and skills to fulfil the role at registration.

7.1.1 Knowledge

Students, assessors, teachers, midwives and supervisors of midwives were in agreement that the three year pre-registration programme had prepared study midwives, at the point of registration, with a very good knowledge base. According to those interviewed, this enabled students to see situations from different perspectives and at registration, qualifiers were better able to discuss and debate issues than previously trained midwives. Interviewees felt study midwives had a "broader" and "deeper" knowledge, which being more research based, provided them with an "excellent theoretical grounding" for practice.

Six study midwives felt there were gaps in their knowledge base in terms of the effects of drugs, including some of the more commonly used midwifery drugs. Five study midwives would have liked to have learnt more, as students, about medical conditions such as diabetes, including the associated physiology. However, midwives, assessors and supervisors of midwives were generally happy with study midwives' knowledge base and the only areas identified where they felt there might have been gaps were in terms of ward management and in terms of answering questions that women might have relating to previous medical conditions.

7.1.2 Skills

In terms of skills, according to assessors and midwives, study midwives had all of the basic skills needed to provide a very high standard of normal midwifery care at registration. However, from interview data, many appeared to lack "hands on" experience, a finding also reported by Fraser (1996) and midwives suggested that the programme placed more of an emphasis on theory than on practice. Thus, study midwives were more competent in theory than in practice. Midwives working with them at the point of registration felt their skills were very raw and that most were still in need of a period of consolidation. They had however all achieved the required EC numbers (EEC 1989) (Article 27).

A few study midwives were identified as lacking certain skills, at the point of registration, which they needed to fulfil the role of the midwife. These included catheterisation (*n*=4), episiotomy (*n*=6), applying fetal scalp electrodes (FSEs) (*n*=2), administering drugs (*n*=7) and two study midwives still needed someone to check vaginal examination findings (VEs). While the programme provided a good theoretical understanding of how to carry out these skills, these particular individuals felt they had not had the opportunity to gain enough experience as students to develop the skills. There was no suggestion that these study midwives would be unsafe as they were aware of the need for supervision in these areas until they had developed sufficient dexterity and capability to be competent. However, a few supervisors of midwives, midwives and assessors were alarmed at the possibility that students could have qualified without being able to carry out catheterisation or an episiotomy.

> *"I mean that surprises me as an older midwife, because in my day I used to do loads of episiotomies, but I didn't suture them, but now they seem to be more proficient at suturing than they are at actually doing the episiotomy". (supervisor of midwives)*

> *"... maybe with some of them episiotomy but then even with post-reg I think because they're done so infrequently perhaps [she] thought she was quite proud of really [that] she hadn't actually performed an episiotomy or if she had I think she'd only done one". (supervisor of midwives)*

> *" I mean I find it amazing that we're actually getting girls through now and it's not the pre-reg .... that have never infiltrated perineums, have never done an episiotomy, you know have never done any these which at one point one would regard as extremely basic things, prerequisites of midwifery, but I think that's the trend more than these girls". (midwife)*

> *"she's only just done her first episiotomy which I find a little bit .... you know, because she's right at the end .... she's taken her finals now then they've just done one. I mean I know they don't do as many, but there's little things like that, that really she ought to have had a bit more experience". (assessor)*

7.2 Consolidation

Most interviewees felt an initial settling in period was required where midwives could concentrate on consolidating their practice and building their confidence in terms of normal midwifery care. Seven study midwives were pleased to have been allocated mainly to delivery suite after registration and some believed they had been specifically allocated to delivery suite to allow this consolidation to take place. Four other study midwives who had little delivery experience in the first year would have liked to have more. New and experienced midwives felt it was necessary to consolidate the normal before learning new skills or gaining experience of abnormal or complicated cases and some felt progress had been impeded where consolidation had not been facilitated.

> *"I think that the first year's a consolidation year and I think people once they're trained, that year should be the same, and don't feel there's any difference". (supervisor of midwives)*

> *"I saw her just after she came back as a supervisor and suggested that she consolidate her basic midwifery rather than trying to take on too much all at once. So that's what she's doing really. She's gradually building up her skills". (supervisor of midwives)*

> *" I think when they're seconded out to the work area, they probably need to consolidate that which they had been learning before you introduce something else". (midwife)*

> *"... [developed] quite well, well in some aspects I mean obviously not at all in the delivery suite area, .. I mean I still haven't done any deliveries on my own yet". (study midwife)*

While some interviewees saw this period of consolidation as standard for any new midwife, others believed that within a three-year programme students should have

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had more time to consolidate practice by the end of the programme. To allow this to happen in the future, students would need to cover all aspects earlier. In this way they would be ready, at the point of registration, to take up the role of the midwife and to develop post-basic skills and abilities. Several possible reasons why individual students had not consolidated were put forward:

- Students did not begin their clinical midwifery placements until late in the programme and were still trying to achieve the EC requirements at the end of the programme when they should have been bringing all areas of practice together

- Students had been allocated to the clinical areas initially as observers when they could have been learning some preliminary skills which could be integrated into practice later

- Students had short periods in each clinical area so that continuity could not be achieved, and these midwifery allocations were interrupted by study days and non-midwifery placements

- The balance of hours on the programme was weighted more towards theory than practice, and this resulted in students not having enough "hands on" experience

- Assessors were not properly prepared or did not fully understand what should be expected of pre-registration students and were not aware of what they were required to teach students. Hence valuable learning opportunities were sometimes missed.

After qualification, study midwives who had been allocated to high-tech units, where they had little normal midwifery experience, found it difficult to consolidate practice. In addition, those working part-time or in an "integrated team" often felt they were lacking the continuity needed to consolidate practice.

7.3 The role of the midwife in normal pregnancy and childbirth

Students and qualified staff interviewed remarked that study midwives had been well prepared to fulfil the role of the midwife in providing normal midwifery care and, as previously stated, students saw the focus of midwifery care on normal pregnancy. This focus on normal midwifery meant that many students were given limited opportunities to even assist with high risk pregnancies and labours.

When faced with these situations, study midwives felt they needed considerable support from more experienced midwives:

> *"I've still got sort of a lack of experience with complications, sort of diabetes, I've looked after a couple of women but I don't feel confident, you know, pre-eclampsia, I've looked after a few, but things like twins and breech, I haven't seen enough of but that's just pot luck I think, if you're there you're there, if you're not, you're not and obviously you can't have a lot of students or midwives, you know, watching, like a peepshow. But I have cared for them antenatally and postnatal and in early labour". (study midwife)*

> *"Yeah I mean with abnormal things then .. I mean the other day somebody gave me a diabetic lady and I gave her back two seconds later, I said no I'll come with you and we'll do it together, because ... I've never had a chance as a student, I haven't got a clue, so there's been things like that. I've had sort of a first chance of delivering abnormal babies, experience with still births, things like that I've never had as a student because I was quite, well I don't know lucky I suppose as a student in a way, because I'd had quite nice experiences". (study midwife)*

> *" ... always dealing with emergencies, and .... I still haven't had enough of those to feel calm about it but um I think really that's the only area where I feel I need a lot of help". (study midwife)*

Midwives and supervisors of midwives agreed that study midwives were well able to provide care for normal pregnancy and childbirth but needed a lot of support when there were complications. Although anxious or unsure at first, by the end of the first year in practice many had developed well in this area:

> *"...I think she's fine at basic midwifery care, I think when it comes to the abnormal side, I like them to, and you know we discuss this when they come on there, I like them to have a idea of looking after their complicated cases, I mean it doesn't inhibit me from giving them complicated cases but ... I like them to sort of keep me more up to date than the other midwives do, and you know what decisions they're doing, that's not to challenge their decisions, it's just a reassurance on my behalf." (midwife)*

> *" .. I can remember one instance I suppose, where this lady obviously became more of a nursing kind of patient than she was a midwifery kind of patient and then obviously there was a lot of input. Obviously she - I think it was bowel obstruction this woman developed which then becomes more surgical rather than obstetric. Then you see you end with a bit of a problem.... obviously abnormal midwifery she'd need more of an input on". (midwife)*

> *"... [she] needed a lot of reassurance and advice but really over an awful lot of things, and certainly the more abnormal things, probably the absolute normal, she was quite happy with." (midwife)*

> *"...she'll like if you've got somebody who's a PIH .... whoever, she'll actually ask to look after people like that, so she's, she's not afraid in coming forward, so I don't think so. Maybe ..... no, even theatre she's quite competent". (supervisor of midwives)*

A few supervisors of midwives suggested that any midwife would need help with the more unusual complications:

> *"....... Well, possibly with problems we all need some support some time". (supervisor of midwives)*
>
> *".... well I think all midwives do [need support], but certainly in care of the bereaved and stillbirths and this sort of thing". (supervisor of midwives)*

One or two interviewees suggested that perhaps students were being prepared for community-based or midwifery-led care where the emphasis was on caring for normal pregnancy and referring when complications occurred. Indeed some experienced midwives felt threatened by the possibility that two types of midwives could eventually emerge with one type involved in normal pregnancy and one with complicated pregnancy and that both types might not be equal in status. This concern should be interpreted with caution as it might have less to do with these new pre-registration programmes than with current schemes to re-organise the maternity services as a consequence of the *Changing Childbirth* Report.

7.4 Post-basic skills

Many assessors, midwives, managers and supervisors of midwives talked about a set of skills which students would need to develop following registration. They implied that such skills would not be expected of students at registration and they include some of those described as "enhanced role activities" in a recently published ENB commissioned study (Pope et al 1996). These skills included suturing, interpreting CTGs, topping up epidurals, inserting prostin, applying FSEs, IV cannulation and administering IV drugs and study midwives would be given support to develop them.

> *"she's gonna hopefully be down there for another four months. So hopefully at the end of that she's still getting her extended role*[1]*, suturing, and things like this". (midwife)*
>
> *"I class the, not so much suturing but sort of scrubbing and topping up epidurals as things I consider as extended roles, wouldn't you?" (midwife)*
>
> *"All the midwives here are taught to cannulate and I think that [she] hasn't actually even started that skill. But it's one of the things that I feel is less important. I like them to try to get the suturing under their belt first of all, because cannulating is an extended skill really, isn't it? Whereas suturing is very much within the role of the midwife" (supervisor of midwives)*
>
> *"...well she's gone more on to the sort of extended role skills if you like. Things like epidural topups .... Water births she's very keen to take on and she has witnessed a couple of those, so she's keen to take on that skill and.... suturing is something that she's very keen to take on and is gradually working towards that." (supervisor of midwives)*

In many cases the skills were included in induction programmes for all new midwifery staff and in some cases study midwives had developed them before registration.

7.5 Management skills

Midwives, managers and supervisors of midwives were divided as to whether three-year pre-registration midwives should have ward management skills at registration. However, in focus group work, participants felt it was important that midwives at registration should be able to manage their own workload and manage their own time well. Study midwives who were said to have had experience only in terms of managing care on a one-to-one basis as students, found it difficult to switch, upon qualification, to having to manage their own time and prioritise when caring for a group of women, especially in the context of a busy ward. Some midwives talked about the problems of rationing the time they could spend with individual women. Ward management was one area where midwives and supervisors of midwives felt many study midwives developed considerably following registration. In some institutions, there was specific theoretical input on management with a small amount of experience of being in charge of a ward as students. However, only some of the study midwives from these institutions found it enabled them to manage a ward immediately following registration.

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[1] It is interesting to note that many midwives described these skills as "extended role". This term used to be used in nursing but was never adopted by midwives as they are expected to learn new skills as contemporary midwifery practice demands.

7.6 Teaching Skills

At the point of registration, study midwives felt well prepared with knowledge and communication skills for one-to-one parent education but felt they were lacking experience of teaching to groups. During the first year, midwives and supervisors of midwives felt study midwives became more confident and effective as educators as they gained more experience to back up what they were saying to women. Study midwives did not feel ready at registration to teach students but by the end of the first year in practice many felt ready to teach. In order to gain the necessary skills they were planning to take up mentor/assessor courses or felt they had skills and were already involved with students.

7.7 Counselling skills

Some study midwives had counselling skills before entering the programme and continued to develop them throughout the three years. One area identified by midwives, managers and assessors, where study midwives developed in the year following registration was in terms of dealing with bereavement and loss. Quite a few study midwives felt they had been shielded from such experiences as students and actively sought to be involved after registration. For others, having to deal with bereavement and loss came unexpectedly and "knocked" their confidence.

7.8 Client advocacy skills

In Chapter 5 study midwives were portrayed as being committed to midwifery and seeing themselves as client advocates. In many cases, although the commitment to being an advocate was there, study midwives and their colleagues felt they needed to develop the skills required to be an advocate such as diplomacy and assertiveness. Most of this development appeared to have taken place at the end of the first six months following registration. At this stage, study midwives said they felt more confident and happy with their role. They also felt that they had become integrated into the team as a valued member of staff and more comfortable with being accountable and responsible for their practice. Accounts are given by study midwives and their colleagues of situations where midwives had to use their client advocacy skills:

> *"... she's proved herself to be quite ..... she's very very much the woman's advocate, she's very, very sensible and caring and .... she's been in a few situations where she could have actually sort of crumbled and sort of handed over care to other people, but she's been in a few demanding situations where she's had to you know really stand her ground, you know situations that probably wouldn't have been you know, probably consultants have come along and said we want you to do so-and-so and so-and-so". (midwife)*

> *"But I think partly that is her personality ....she would really challenge anything that she felt was wrong for her clients and really want a very good answer if she was to go along with that. So she's a very good advocate." (assessor)*

> *"[She] is the patient advocate, and I think sometimes she's so nervous of the interference .. and being in the junior position, and she really practises from a research base .... but she has got the patient's interest at heart" (supervisor of midwives)*

7.9 Communication skills

Although the need to be an effective communicator has been addressed in previous chapters, the acquisition of specific skills was seen as vital, for safe and competent midwifery practice. There was total agreement that the programme had enabled students to communicate with women and their partners using methods appropriate to context.

7.10 Summary

Being safe and competent implied to interviewees that

- midwives used research to inform practice
- were able to provide the full range of care for normal pregnancy
- could detect deviations from normal and take appropriate action
- would ask for help with any situations if they were unsure.

However, interviewees could not be sure that three individuals would fulfil these criteria. Interviewees also wanted midwives at registration to be confident but not over-confident and most problems that students had at registration, in this regard, were resolved by the end of the first six months in practice. Study midwives were aware of the importance of being safe and what it entailed.

Interviewees felt study midwives had a comprehensive knowledge base but some gaps were noted in terms of some aspects of drug administration and knowledge of medical conditions. Study midwives had all of the essential skills for the role of the midwife but these were seen by colleagues as "very raw" and study midwives needed a period of consolidation following registration. In a few cases, particular gaps were noted in terms of catheterisation, episiotomy, administering drugs and confidently interpreting VEs.

Study midwives were shown to be very capable to provide care in normal pregnancy but to need considerable support when caring for women who were ill, had pre-existing medical conditions or developed complications. Areas where students had had little experience as students and where most development occurred following registration included ward management skills, counselling skills and teaching to groups of women and to students. Although study midwives had some experience as students in terms of managing their own workload, managing time and prioritising, and advocacy skills, these areas could only be fully developed following registration.

Key Issues

- Midwives qualifying from these programmes demonstrated a good knowledge base and understanding of research to provide safe midwifery care (7.1)

- All but three students appeared to have the "right level" of confidence to recognise their own limitations, detect deviations from the normal and seek help appropriately (7.1)

- Some skills had not been developed sufficiently for all study midwives to undertake them without assistance, eg catheterisation, episiotomy, epidural "top-up" and drug administration generally (7.1, 7.3, 7.4)

- It is suggested that programmes should be designed to enable students to learn skills earlier in a structured learning context (7.2)

- It would seem important for assessors to help students capitalise on all relevant learning opportunities, drawing upon theory appropriate to stage in the programme (7.2)

- A period of time was needed to consolidate skills, especially those used during the intrapartum period (7.2, 7.3)

- Areas most in need of development post-registration were: (7.4)
  management skills (7.5)
  group teaching skills (7.6)
  advocacy skills (7.8)
  bereavement and loss counselling (7.7)
  care of women with complications (7.3)

CHAPTER 8

THE FIRST YEAR IN PRACTICE

8.1 Introduction

All thirty-nine case study students were followed up for a year post-registration as midwives. All achieved some form of employment on registration and with only one exception where due to personal circumstances the participant could not be available for interview, all were followed to the end of the first year after registration. This longitudinal study has enabled accurate data to be collected in relation to career patterns, career intentions and learning needs of these new midwives during their first year in practice. Whilst the study sample could be considered small, it represents programme completers from six very different midwifery education institutions throughout England. Unlike the Department of Health study "Getting a Job and Growing in Confidence" (Maggs et al 1995), there is no missing data. A comprehensive range of abilities is also represented with some case study completers being described as "exceptional" students whilst others just achieved an acceptable standard to qualify for their diploma or degree and eligibility to register as a midwife. It is suggested therefore that there is a reasonable basis for arguing that the issues that emerged are of some relevance to all institutions involved with the three-year pre-registration midwifery programme.

Data for this phase of the project were collected through interviews with the case study students (now midwives). These were tape recorded telephone and face to face interviews. Triangulation of data was obtained by interviewing midwives who had worked closely with the case study midwives as well as supervisors of midwives and midwifery managers. Including study midwives in focus group interviews enabled further exploration of some of the issues that emerged.

8.2 Career Patterns

As can be seen from Table 8.1, all but two of the case study midwives secured some employment in NHS Trusts. Thirty-four had permanent or temporary contracts at registration and a further three were given contracts after four to seven months as agency or bank midwives. By the end of the first year following programme completion, 95% (37) were working in midwifery. Of the remainder, one gave up midwifery for personal reasons and the other had chosen to seek employment outside midwifery, but in a field where midwifery knowledge was helpful. Towards the end of the year, she told us about her plans to do some bank work at a local hospital in order to keep her midwifery skills up to date.

The peaks and troughs of midwifery vacancies were the cause of on-going temporary contracts. However, case study midwives in these posts were led to believe that they would not have to wait too long before their posts would be made substantive. Other new qualifiers had to work temporarily on gynaecology wards and neonatal units until the managers had vacancies in the midwifery areas.

The percentage of midwives given part-time contracts remained fairly constant throughout the first year. Some were deliberate choices, because of child care commitments whereas others were according to availability. Those who worked part-time generally felt they had not been able to consolidate their practice as well as their full-time colleagues.

> *"Well I think I would have been better if I could remain fulltime, because you just need lots and lots of experience but I have lots and lots of problems with child care, and I can't work in shifts as well. .....there's still lots to learn but .. I suppose thinking about it I*

> *am starting to pick them up, but it just seems, I'm sure if I was fulltime and rotating on to days and having students I'd be learning them a lot quicker so it's probably my own impatience thinking I should be you know three steps further on and I can see some of my colleagues already there" (study midwife)*

Table 8.1 CAREER PATTERNS OF STUDY COHORT IN FIRST YEAR OF PRACTICE

Type of contract

Registration	*n*	%	Six months	*n*	%	End of year	*n*	%
Permanent*	17	44.00	Permanent*	29	74.00	Permanent*	33	85.00
Temporary	18	46.00	Temporary	7	18.00	Temporary	5	13.00
Bank	1	3.00	Bank	1	3.00	Bank	0	0
Agency	2	5.00	Agency	1	3.00	Agency	0	0
Unemployed	1	3.00	Unemployed**	1	3.00	Unemployed	1	3.00
Total	***39***	***100***	***Total***	***39***	***100***	***Total***	***39***	***100***

Full-time or part-time

Registration	*n*	%	Six months	*n*	%	End of year	*n*	%
Full-time	27	69.00	Full-time	28	72.00	Full-time	29	74.00
Part-time	8	21.00	Part-time	8	21.00	Part-time	9	23.00
Total	***35***	***90.00***	***Total***	***36***	***92.00***	***Total***	***38***	***97***

Area of practice

Registration	*n*	%	Six months	*n*	%	End of year	*n*	%
Hospital	32	82.00	Hospital	33	85.00	Hospital	35	90.00
Integrated team	1	3.00	Integrated team	1	3.00	Integrated team	1	3.00
GP unit	1	3.00	GP unit	1	3.00	GP unit	1	3.00
Non-midwifery	1	3.00	Non-midwifery	1	3.00	Non-midwifery	1	3.00
Total	***35***	***90.00***	***Total***	***36***	***92.00***	***Total***	***38***	***97***

*Includes one midwife in non-midwifery position % rounded to nearest whole

** Different midwife to one unemployed at registration

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By the end of the year the majority of study midwives were working in hospital positions. More than half of the study midwives explicitly stated that they would like to work in community-based teams or group practices in the future but were happy to work in the hospital in the short term so that they could get experience and become more confident. They saw this period following registration as a time to become comfortable with the role of the midwife and to learn post-basic skills which would be necessary for them to provide the full range of care on the community. Two midwives worked in such community based practices from registration and although they enjoyed the work which they found was based around *Changing Childbirth*, they found it difficult to consolidate their practice as they only had very short periods on delivery suite and they found they did not have the same support as their colleagues when, for example, making decisions.

> *"I think the first six months when I'd qualified I came in thinking, this is what I wanted to do working, both in the hospital and out in the community, and on reflection on that I would I would think it's good for you to get a little bit more confidence in the hospital before going out into the community, before trying to sort of be split in different directions because you don't consolidate, you do take a little bit longer to feel confident with everything that you're doing, and I did feel a bit broken up at some stage as you know, I was no good at this and I was no good at that, I did feel a bit disjointed" (study midwife)*

A few study midwives chose to move to other units during the year to work in "low-tech" units or with particular case mixes or to be better supported as midwives.

8.3 Plans for the future

Table 8.2 sets out in detail career intentions of study midwives at the end of their first year in practice. Appendix 7 gives more detail of the individual career patterns of the student midwives in our sample.

Although many had only made short-term plans and had several options to consider for the future, more than half of study participants had some plans for further study, and planned courses ranged from top- up degrees or masters courses to ENB 997 or teaching courses, to more clinically orientated courses. For the majority of study midwives, their immediate plans were to consolidate their practice and more than a fifth stated that they planned to stay as clinical midwives with no ambitions towards promotion.

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Table 8.2 FUTURE PLANS OF STUDY MIDWIVES (In rank order)	***n***	**%**
Further study (degree, M Sc etc)	10	27.0
Integrated team	9	24.3
Working as a midwife abroad	9	24.3
Community	8	21.6
Stay as clinical midwife - not interested in promotion etc	8	21.6
Further midwifery related course - (997, parentcraft, research)	8	21.6
Normal care / midwifery-led care	7	18.9
Teaching; teacher/practitioner role	4	10.8
Independent group practice	2	5.4
Further course 405 (neonatal nursing), 943 (HIV & AIDS)	3	8.1
Thinking of leaving midwifery / moving into another area	3	8.1
Hospital-based care	2	5.4
Research as a part of midwife's role	2	5.4
GP Unit	1	2.7
Caring for women with psychiatric problems	1	2.7
Taking a break for present	1	2.7

Of the nine midwives who were interested in travelling abroad to experience midwifery there, one left as soon as she had completed her first year as a practitioner. Along with the lure of warmer climates and the adventure of travel, midwives were interested in practising abroad to experience midwifery-led or low-tech care, and some suggested that this was not possible currently in the UK.

In terms of retention in midwifery, one new midwife, for personal reasons, had decided to take a break from midwifery for the present, while two other new midwives had become disillusioned with the midwifery service as they saw it, felt extremely pressurised with the hospital workload and that they could not provide the quality of care which they felt they should. While one of the two had decided to move into a midwifery-related area so that she could still use her midwifery skills, the other was determined to continue practising at present but alluded to the possibility of leaving midwifery in the future if things did not improve. Another new midwife thought she might move out of midwifery and into research in the future.

8.4 Supporting new midwives during their first year as practitioners

More than half of the study midwives felt they had adequate or good support initially at registration, although there was always room for improvement. These midwives had been allocated to an induction programme or to work with preceptors, or had received good support from team leaders, managers and team midwives. In many cases, where preceptorship had fallen through, team members had stepped in to bridge any support gaps.

> *"Well I chose a preceptor while I was there, or at least certainly have one for the first six months. I haven't actually seen her for a bit because she's had a month of nights and various other things. But we managed to sort of sit down and talk about things in general. And I've been very well supported by our clinical midwifery manager, who's always .. I mean before I went on the course she was very supportive then because she knew what I wanted to do. I think .... well the support of other midwives .. of being able to say you know well what should I do next? or this is what I've come up with, what's the procedure? So it's a sort of support of people who've worked there for a while and also qualified for a good few years that have been able to either check something or I've felt well able to ask questions" (study midwife)*

In addition, study midwives received support from each other and from core staff on delivery suite. New midwives felt well supported when they felt they could turn to any midwife if they had a problem and were not worried about being ridiculed or criticised for lacking knowledge or ability.

> *"Well we've had a preceptorship for the first 3 months after training and that was excellent ...... I have been very very lucky, and .... most of the midwives on that ward I could turn to for any advice without feeling ridiculed or, criticised for my lack of knowledge or ability. So it's been a very very good balance" (study midwife)*

Most of this group of study midwives felt they were not in need of close supervision but needed to know that they had the backup of having someone else on hand to consult with should a problem arise and or until they became more confident making decisions. Initially at qualification, study midwives felt they needed a lot of support to 'double-check' decisions but this need for support soon tailed off as they became more confident. In addition, they needed support from supervisors of midwives, managers and team leaders to be able to reflect on practice and to be able to identify and meet learning needs. Feedback on progress had been very helpful to building confidence.

Forty-two per cent (*n*=16) of study midwives felt they had needed more support than they had received, especially in the first few weeks following registration. Although midwives were willing to help, they were often very busy or not always available when new midwives needed them. Midwives would have liked more feedback on their development and to have someone to talk through cases, they felt this would have helped them to become more confident. A few midwives who had not learned to suture the perineum as a part of their pre-registration programme found it difficult post-registration to find someone to teach them. In a team, midwives tended to work alone most of the time so that new midwives might find themselves suddenly having to make decisions alone.

> *"I don't think I realised just how much greater the responsibility would be, particularly working in the clinic and the community and I mean it's you to make the decision and you know it can be quite frightening sometimes thinking are you making the right decision". (study midwife)*
>
> *"Well it's the doing the night duty in that we are totally on our own there really, we don't have any [doctors] or anything so that we are, you know [the] decisions that we make, are really important. I think I've found that quite hard" (study midwife)*

In a few cases, staff were not aware that study midwives were newly qualified or of their support needs. Twelve study midwives who moved to units new to them at registration also needed support to learn about local policies and to become familiar with the unit. However, of the 16 midwives who said they would have liked more support at registration, only 4 had moved to new units. At one site, study midwives who had gone to a new unit at registration received better support (formal induction course) than their colleagues who remained at the site where they had trained.

Study midwives who experienced a sudden withdrawal of the level of support that they had had as students talked about feeling that they had been thrown in the deep end at registration. The area highlighted by study midwives and their colleagues where the greatest support was needed was in terms of helping midwives to cope with being suddenly accountable and responsible for their practice, especially when they were aware that there was so much more for them to learn. Those who took a longer time to settle into the role or who were still functioning in student mode, needed a lot of guidance and support from ward and senior midwives. According to midwives, managers and supervisors of midwives, they needed considerable support to take on the role of the midwife and to recover from a significant drop in confidence at registration. New midwives also needed support to develop the skills to manage a ward as many had little experience of management as students. Interviewees suggested that their needs for support in the management context may have been greater than shortened programme midwives, many of whom would have had ward management experience prior to studying midwifery. A few managers and supervisors suggested three year midwives needed support for a longer period of time following registration than shortened programme midwives, and were concerned about the cost implications of having to give such support. However shortened programme midwives are not a homogeneous group, some might have years of nursing experience whereas others might be straight from initial nursing education programmes at certificate, diploma or degree level. Almost half of the midwives, managers and supervisors of midwives interviewed felt the support needs of study midwives were no greater than those of any newly qualified midwife, focusing mainly on confidence building and decision making. Similarly to shortened programme midwives, they needed most support on delivery suite especially when dealing with abnormal or complicated cases.

Data from study midwives and from supervisors of midwives, managers and midwives working with them suggests that most study midwives were confident by the end of six months and at that stage only needed general backup for areas where they were unsure. Seven study midwives were felt to still need more support than general backup at this stage. This was because they lacked confidence managing a caseload (in terms of prioritising or organising work), on delivery suite or when dealing with complicated cases or new experiences (such as stillbirth). Even though the majority of new midwives needed support at registration to build confidence, a small number (*n*=3) were considered to be over-confident by midwives working with them, who felt they needed support to be made aware of the need to ask for advice and to value the experience of more senior midwives.

> *".. if you ask her she'd probably say not a lot [of support], you know she seems incredibly self-sufficient, which has made me sort of want to sort of be available and to actually follow her up and chase her quite a bit more than I would normally do, because I can't believe anybody who's just qualified can be quite as self-sufficient as that". idwife)*

> *"I think at times individual midwives have felt the need to actually encourage her to talk about you know, to actually express any worries she has rather than to sort of plough on regardless" (midwife)*

However, data from an interview with one of these midwives (midwife A) suggests that her attempts to develop her own style were misinterpreted as her being over-confident.

> *" .... in my elective at the end of very end of my training, I had a period of preceptorship then, and in fact it worried me more that they were going to appoint a preceptor, and I wouldn't necessarily ask advice from everyone I work with, I would be selective, and I felt that it would be more beneficial to me to confer with midwives who I felt shared more my philosophies than to have an appointed preceptor who I may well clash with quite considerably"(study midwife A)*

There is little evidence from interviews with the other two midwives that they were over-confident, as the following responses to questions about their development needs illustrate:

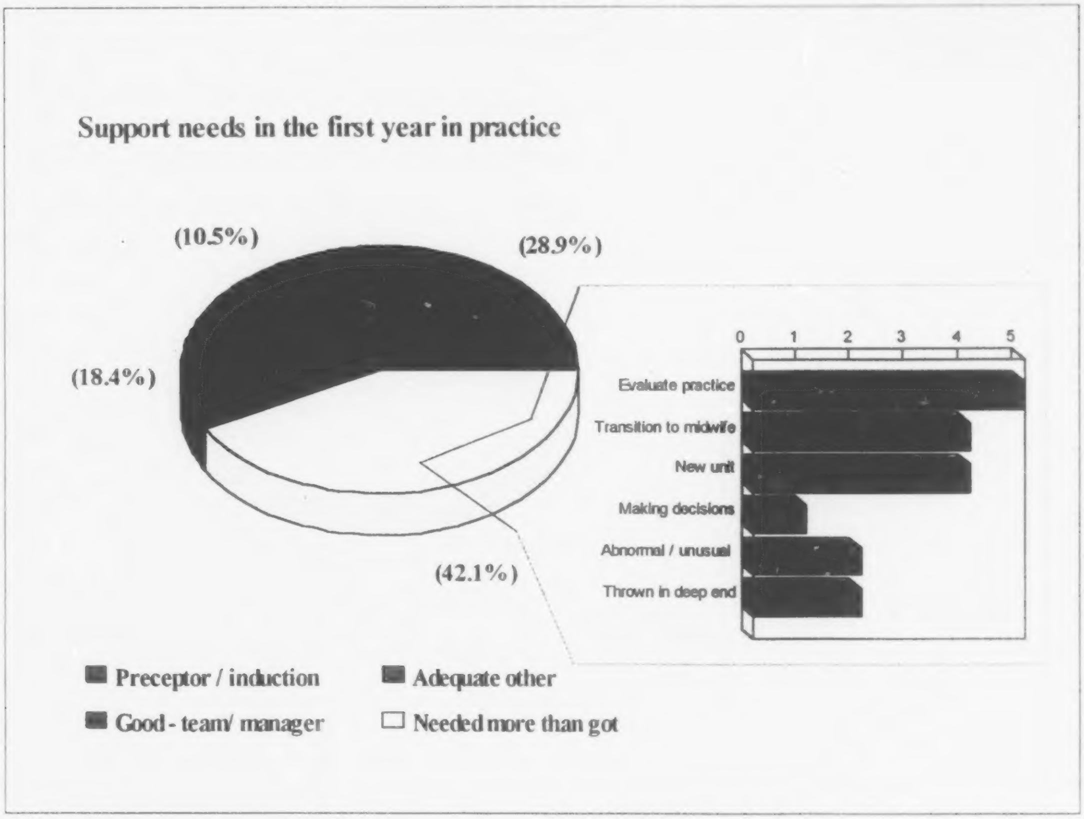
> *"............. just confidence really. And confidence in making decisions myself without consulting anybody else, I think. And also very, well in fact very important, if I think I'm sure about something and I discuss it with a doctor, like a decision they want to make, then I'm very easily swayed (laugh). If they say well I don't think so. I'm very easily intimidated and I think all right, well you know I suppose you*

> *know something I don't know. And that's definitely something I feel I want to really get into and you know be able to believe that I'm just as good as them" (study midwife B)*

> *"... it never bothers me to ask for help if I'm unsure about anything. And I think that's probably why I perhaps feel a little bit more confident than some of the others, because I'm quite happy to go and say look, what about this, or tell me a bit more about this, ... And I think as long as you've got the backup there and you're prepared to go and say I'm not sure, it's knowing the midwives' own capabilities and recognising your own limitations and when you need to call for help" (study midwife C)*

Perceived support needs also varied from individual to individual, within case study sites and between contexts. Some individuals appeared to be more assertive and more ready to take on the role and responsibilities of the midwife whereas others lacked confidence in their abilities and needed considerable encouragement and reassurance from their colleagues. Within case study sites, some individuals were described as excellent whereas others were lacking in confidence. There were also differences in how managers interpreted support needs with some providing some very structured support including induction courses for all new midwives, employing all pre-registration midwives as supernumerary initially at registration or the allocation of new midwives to preceptors. At other sites, new midwives depended on team members, often under the direction of team leaders, to provide support. Figure 8.1 shows how study midwives described the support that they had in the first year.

Figure 8.1



8.5 Learning needs during the first year in practice

The learning needs of study midwives during their first year have been explored by allowing the main areas of concern of interviewees to emerge and by then examining each by the three dimensions in our model of competence. As stated in Chapter 3, the three dimensions are integrated so that the model of competence is holistic. This implies that competent midwives are able to draw on all three dimensions of competence to varying degrees depending on the situation at the time. This ability to integrate the dimensions appears to form the final stage of the process of becoming competent and involves a period of consolidation, becoming confident and learning to cope with responsibility and accountability.

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Development in this area spans the three dimensions and is difficult to describe under each one separately, reinforcing the notion of competence as a holistic, integrated phenomenon.

Consolidating practice

The data from assessors, midwives and teachers suggests that students, at the point of registration, had a very good and broad knowledge base for the role of the midwife, that most had no particular gaps in ability and, at that stage, had needed guidance rather than teaching. However, it appears that most had not had sufficient experience of the total role to have become confident and indeed at registration many experienced a sudden and serious drop in confidence. The need to consolidate practice was identified as a priority for students immediately following registration by students, teachers, assessors and midwives. Consolidation and confidence building appeared to be particularly difficult for study midwives who had initially taken up positions in units focusing on high-risk and complicated care.

Several suggestions are raised about why study midwives had not consolidated practice before qualification. Although from the data there appears to be a strong relationship between consolidation and confidence building, there is no consensus as to what level of consolidation should be expected of students before registration. Clearly if midwives were to function as independent practitioners at the point of registration, as they are entitled to do, then they would need to be confident. However, there was general agreement from interviewees that there is a need for a certain amount of consolidation at registration, which would also apply to shortened programme midwives.

'Flexible allocation' at the end of the programme appeared to be used to target skills which were lacking rather than using this time to consolidate practice. Some students were lacking particular experiences because clinical learning opportunities had not arisen or had not been taken and the possibility was raised that this might be more likely to happen now given the current emphasis was on students experiencing holistic care. With such an approach, students could not be guaranteed to have certain experiences that they would have if they were following a task orientated curriculum approach or tick list of objectives.

In terms of the organisation of clinical allocations, assessors suggested that students needed to be allocated to clinical areas sooner in the programme to learn skills earlier which could be integrated then into practice so that they would have the full range of experience and some consolidation by registration. Some students felt assessors had lacked direction as to how students could make best use of their time in clinical areas and that they needed to be prepared better for what experiences were appropriate for three-year pre-registration midwives. They felt some assessors had assumed that students already had the skills in question based on their experiences with shortened programme midwives. Although some experiences, such as episiotomy, were difficult for students to obtain because of changing practices, some students also felt they had been shielded from important experiences, such as dealing with loss and bereavement. Teachers also alluded to the possibility that although the programme covered everything in the theory curriculum, they could not be sure that students would have had all the experiences that they would have needed in order to use theory in practice. This suggests the need for closer links between the school and assessors, and also assessors having more direction from teachers on what experiences students need to gain.

The remainder of the chapter now draws together under the three dimensional model, the most important issues emerging during the first year of practice.

8.6 The Professional/Friend Approach

At registration study midwives were required to become responsible and accountable and taking on such responsibility represented 'a quantum leap' to some and required a period of adaptation - a period of 'mentally living with that shift in dimension'. Study midwives were not only putting all areas of practice together during the consolidation period but also gaining experience of practising as accountable and responsible practitioners. Some midwives had difficulty coping with being accountable when they did not consider themselves to have reached a stage where they were able to integrate all aspects of the role of the midwife instinctively into the provision of care and this appeared to account, at least partially, for falling confidence at registration. Teachers saw this process of synthesis as vital and were concerned that some students might not get the opportunity to complete the process if they could not get jobs soon after qualifying. Fortunately teachers' fears about the job situation were unfounded and most study midwives appeared to be very capable of working as practitioners in their own right at six months but needed support or 'a little bit of guidance' from time to time on delivery suite. One or two midwives were still lacking in confidence on delivery suite or antenatally and needed to be able to talk things through with more experienced midwives. By the end of the first year most study midwives were ready to take on more responsibility, for example teaching other student midwives.

Study midwives were also lacking in experience of making decisions and this was an area where they developed after qualification. Also with consolidation and improving confidence, study midwives became more assertive, especially when dealing with doctors and other team members. During this time, experienced midwives saw their role as ensuring that new midwives knew who to go to if problems arose and making themselves available to discuss any unusual cases.

Students themselves saw this period as a time of on-going learning, becoming more proficient and 'getting the feeling that you know what you're doing' rather than learning anything new.

8.6.1 Acknowledging limitations and identifying learning needs

Most students at the point of registration said they were happy to admit that they did not and could not know everything at the point of registration and would seek help from a more experienced midwife if they were unsure about something. Assessors and midwives acknowledged that midwives could not know everything at registration. They considered midwives to be safe provided they were aware of the limitations of their abilities and the sphere of practice of a midwife and would not be afraid to ask for help or advice. Midwives and supervisors of midwives were impressed that study midwives were so well able to identify their own needs for development as they were aware of the huge amount of learning that takes place after registration.

8.6.2 Communication

Examples of where students were effective communicators at the point of registration were provided. However, a few needed to become more confident and assertive when communicating with other colleagues. Most continued to develop as communicators following qualification with more experience of dealing with families and other team members and having experience to support what they are saying. This development involved becoming more sensitive, being better able to judge communication needs and being able to communicate at a level appropriate to needs. Evidence of study midwives developing a special relationship with women was rarely made explicit but this does not imply it did not happen.

8.6.3 Management

When three-year and eighteen month pre-registration midwives were compared at the point of registration, the difference most highlighted was in terms of midwives ability to manage a ward. Interviewees pointed out that previously most shortened programme midwives[1] would have had the benefit of having had experience of ward management before entering onto the programme, and while study student midwives needed to be able to manage their own workload and time, it was unlikely that they would be required to take charge of a ward. While the majority of study midwives were capable of managing their time and prioritising their work, four had particular difficulty and needed support to develop in this area initially. As students, it appears that some study midwives had little experience of managing care for more than a few women at a time. For these midwives, though care given on a one-to-one basis was excellent, they struggled to provide the same standard of care for all individuals in their care in a larger group within the time span of a shift. They needed to develop an awareness of and ability to cope with 'the wider aspects' of management and events going on around them. They needed to be

> *'...fully exposed to all the knocks and up and downs and the stresses...constant interruptions', '...how to be a midwife and act on your own ....and fit in with a ward-full of others' and to be able to '...come in the morning and take control'. (midwives and supervisors of midwives)*

This was even more difficult for those who found themselves working in a very busy ward context with little support. However, by the end of the first six months, most had developed in terms of identifying priorities, planning work and managing time and were coping well. By the end of the six months, some had been in charge of the ward and had pleased team members with their progress. This notion of the "central importance of time and speed in professional work" has been explored by Eraut (1994b, page 149) and it would appear that study midwives compared favourably with other professional groups in this respect.

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[1] The midwives are referring to pre-Project 2000 nurses who undertook a traditional nurse training programme before changing to the midwifery profession. Most would have been expected to undertake staff nurse experience before being accepted onto shortened programmes.

While there were programmes where there had been specific theoretical input into management and where most students also had this knowledge backed up with some experience, most teachers acknowledged that students did not get much opportunity to be involved in the day to day management side of things and were more focused on individual care. Teachers also suggested that students did not appreciate how important ward management experience would be as students were more orientated towards community practice in keeping with childbirth as a normal physiological process. However, the reality was that in the current service situation, most students would have to work in hospital after registration.

There were also reports of how assessors intended to enable students to have more management experience but it was not possible because the unit was so busy. However, students had experience of 'all of the little jobs' and would only need experience to put it all together. Some believed they would be capable but needed to have the experience to be sure and found the thought of being in charge a bit daunting. While most assessors agreed that study student midwives were fairly capable and would get better with experience, midwives working with study midwives painted a different picture. They felt study midwives had needed quite a lot of input immediately post-registration in terms of ward management. Some appeared to have no knowledge of managing and needed to learn how to get in touch with other team members, what to do in certain situations and how to order drugs. Study midwives had most difficulty when the ward was very busy.

8.6.4 Effective team members

Although as students, many study midwives worked in teams, at registration study midwives felt they took up different responsibilities within that team to those that they had as students. Feeling part of the team helped study midwives to settle into their role and team members provided considerable support for them during the first year, often plugging gaps in support nets as official and planned sources of support failed. As study midwives developed confidence, they began to function better within the team and to begin to provide support and knowledge for other team members. At registration, it appears that study midwives understood the importance of the team and the roles of team members and they appeared to be very orientated towards working in collaboration with other health professionals.

8.7 The Individualised Approach

Study midwives appeared to be well prepared to provide individualised care at the point of registration and continued to develop during the first year in practice. This development was concerned mostly with planning to meet needs and documenting care. Study midwives also had to develop the ability to plan individualised care for a group of women and to prioritise needs for care within the overall organisation of work on a shift. This was very difficult for a few study midwives who found it difficult to cope with the possibility that in having to decide on priorities for care within a busy ward situation, they were only able to attend to the most important needs.

8.8 Clinical Competence

As stated previously under the section on the consolidation of practice, students were equipped with a comprehensive knowledge base for the role of the midwife. However, many felt they were lacking in clinical "hands on practice", had little opportunity to bring all aspects of care together, and were lacking confidence. Study midwives were least confident or felt they most lacked experience on delivery suite and some were purposely allocated by managers to delivery suite so that they could become confident there before taking on other experiences. Some felt they were lacking experience even though they technically had a lot of experience, for example, 48 normal deliveries (40 deliveries are the minimum required). Supervisors of midwives felt it was important that new midwives should be able to consolidate their experience of normal midwifery practice and gradually build up skills before taking on care in abnormal or complicated cases.

8.8.1 Caring for abnormal and complicated cases

There were a variety of perspectives on student ability to provide care in abnormal or complicated pregnancy. The emphasis in curriculum documents is on pregnancy being a normal physiological event and curriculum outcomes in examined programme documents focus on midwives detecting deviations from normal and appropriate referral/action and, at most, refer to assisting in the provision of care rather than on preparing students to care for complicated or abnormal pregnancy. Interviewees were certain that study midwives would be able to provide the full range of care for a woman from the beginning of pregnancy to the end of the postnatal period provided pregnancy and childbirth remained normal. With only two exceptions, they were also sure that study midwives would be able to detect and report deviations from normal and although some would need support, they could take appropriate action when deviations were detected.

While teachers were not concerned about students not being able to care for abnormal cases at registration, almost half of the students interviewed mentioned the help and support that they would need when caring for ill women or women with complications and were worried that they did not have all the skills which would be needed to provide such care. Many said they would have liked more input earlier in the programme on the skills needed to care for women with complications, such as putting up blood, caring for central venous pressure (CVP) lines and dealing with infra-venous infusion. Assessors also had mixed views with concerns expressed about study midwives not having the kind of skills that would sometimes be required to care for ill women and the support that they would need to provide such care. In some centres, it was not possible for students to gain this type of experience, according to teachers, because women with complications were usually transferred to the regional unit. In other centres, assessors felt students had developed all of the necessary skills by registration, including those required to care for complicated cases, and although they would still need support and advice, they felt their learning needs were comparable to those of any newly qualified midwife. Experienced midwives were not concerned that study midwives might not be fully equipped to care for abnormal cases provided they were prepared to admit that they needed help and support when they were unsure about anything and some gave accounts of study midwives looking after more and more complicated cases, in the year following qualification, as confidence improved. At the end of the first six months, some study midwives still needed more experience of abnormal cases including caring for women with multiple pregnancies, pregnancy induced hypertension, cardiac problems, diabetes and acute antenatal problems such as antepartum haemorrhage. During the year many had experience of dealing with stillbirths, loss and bereavement for the first time and coped very well.

8.8.2 Dealing with emergencies

As students, it appeared that study midwives found it difficult to get experience in emergency situations and although they had covered the area well theoretically, they were worried about 'tripping and fumbling about and not knowing what decision to make' if they were to find themselves in an emergency situation. However, they acknowledged that experience was difficult to ensure for students while ensuring that care, which needed to be provided by proficient practitioners, was not compromised. While there were assessors who were concerned that they had not seen students in stressful or crisis situations and were not sure how they would cope, other assessors did not expect that newly qualified midwives should be able to cope in such situations. Most study midwives had experience of emergency situations and of infant resuscitation by the end of the first year.

8.8.3 Skills

Certain skills were identified by most assessors and preceptors as being more appropriate to learn following registration. Some which might be considered as essential to any midwife at registration were also identified as missing in a few cases. There were students who were proud to declare that there had been no need to perform an episiotomy in any of the cases which they had cared for but assessors and midwives were concerned that they were going to qualify without having the experience and would therefore not be able to function effectively as autonomous midwives. Data from supervisor of midwife interviews suggests that some study midwives placed more of an emphasis on learning to suture than on becoming proficient at performing an episiotomy and at the end of the year a few still had little experience. Some study midwives also needed considerable help and support to interpret cardio-tocograph tracings (CTG) and one or two needed to gain experience of VEs, artificial rupture of membranes (ARM), catheterisation, putting up blood and infant resuscitation, although they did have the background knowledge.

Many assessors, midwives and supervisors of midwives referred to a set of skills which they considered not essential to fulfilling the role of the midwife or which they did not expect of midwives at the point of registration. These post-basic skills were included in standard induction or in-service training programmes for all new midwives where such programmes were available and included suturing, topping-up epidurals, IV cannulation, giving IV drugs, prostin induction, scrubbing for theatre and skills for the neonatal unit. Some interviewees debated whether scrubbing in theatre was the responsibility of the midwife. Many students had experience of suturing and topping-up epidurals prior to qualification and some had theatre experience. Study midwives also identified other experiences such as twin and breech delivery which occurred infrequently and which they needed experience of following qualification.

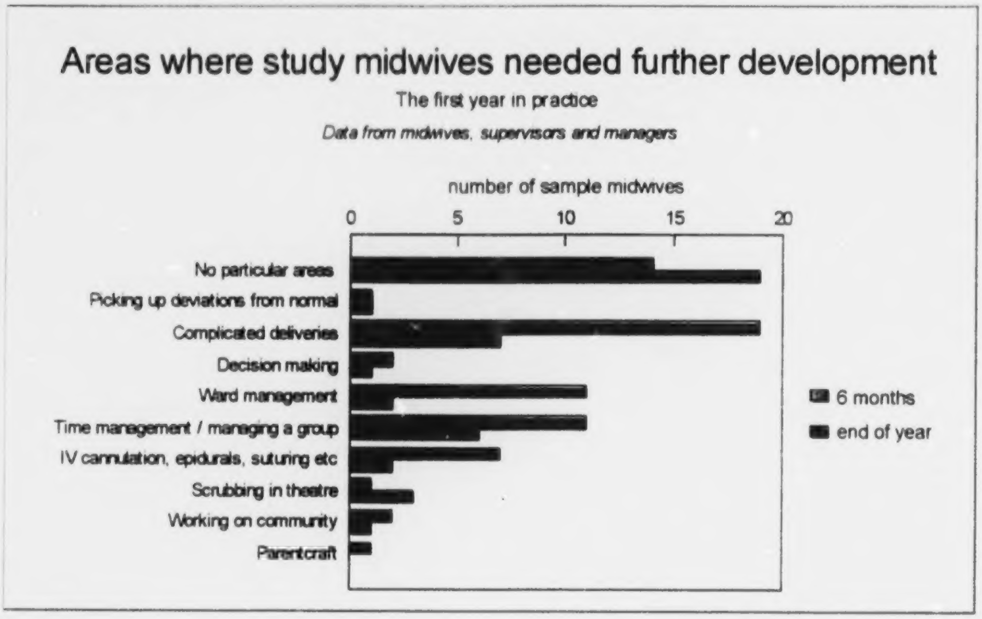
8.8.4 Administering drugs

Students, assessors and midwives felt students were lacking experience in administering drugs. They felt students needed more knowledge of drugs in terms of side effects and interactions of drugs commonly used in midwifery and some students would have liked more information on drugs which pregnant women were often prescribed, although they were not midwifery drugs, for example drugs to control epilepsy. Post qualification, a few study midwives appeared very anxious and unsure when they had to undertake drug rounds. They were terrified of making mistakes and some had little experience even by the end of the year as ward coordinators tended to do drug rounds.

8.9 Needs for development at the end of the first year

Data from interviews with supervisors of midwives and managers at the end of study midwives' first year as practitioners was used to explore their needs for further development. For many, interviewees felt there were no particular gaps in ability or areas which needed to be developed further, with midwives just needing to continue to consolidate and to keep their knowledge and skills up to date. They felt study midwives at this stage were becoming more competent in all areas because as reflective practitioners they had actively sought out areas where they needed experience and strived to have these needs met. They were seen to have consolidated well as practitioners for the role of the midwife in dealing with normal cases and, generally speaking, skills identified for further development were considered to be complementary to the role of the midwife in normal midwifery care. A few felt they needed support to care for abnormal cases and were lacking experience dealing with loss and bereavement. All were well able to provide care on a one-to-one basis but some needed support to manage a caseload. Many were capable of running a ward but still needed reassurance to back up decisions but interviewees would expect that of any newly qualified midwife. Study midwives were aware and in tune with what women wanted but needed to become a little more assertive as advocates. They were also very enthusiastic about research-based practice but some needed to learn to cope and to be tolerant of the styles of other midwives who were experienced and who weighed up research in the light of their own experiences. To summarise the chapter, Figure 8.2 compares areas identified by midwives, supervisors of midwives and managers where they believed study midwives needed to develop at the end of the first six months and at the end of the first year in practice.

Figure 8.2



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Key Issues

- The majority of midwives gained employment in NHS Trusts (8.2)
- Not all study midwives gained employment immediately which affected their ability to consolidate learning and build up confidence (8.2, 8.6)
- Learning skills earlier could avoid the rush to complete essential activities of a midwife at the end of the programme (8.5, 8.8.1)
- Closer links between the teachers and the practice placement assessors could improve use of students' time in clinical areas (8.5)
- A period of consolidation before the end of the programme could help with the transition from student to midwife (8.5, 8.6)
- Variations existed between providing new midwives with good support and "throwing them in at the deep end" (8.4)
- Support for new midwives was needed most on delivery wards and by the least confident midwives (8.2, 8.4, 8.6, 8.8)
- There was a variety of employer expectations of study midwives in their first job (8.4, 8.6, 8.8)
- By the end of the first year most study midwives were described as confident, competent midwives whose speed of development compared favourably with other professional groups (8.6, 8.8, 8.9)

- Some study midwives experienced disillusionment within a maternity service which prevented them from providing high quality, individualised, woman centred care (8.3, 8.7)

- Study midwives were able to identify their learning needs, were keen to undertake further study and in the future to work mainly with low-risk women in the community (8.3, 8.6, 8.9)

CHAPTER 9

BORDERLINE STUDENTS? EVALUATION CASE STUDIES

9.1 Introduction

This evaluation project has produced a wealth of data in relation to the effectiveness of pre-registration programmes in preparing students for their role in contemporary midwifery practice. However, evidence also emerged that failing students is problematic and warrants further discussion. Institutions provided limited data in relation to those whose programme was terminated and the ENB database provided even less information. Concerns have been expressed to us in interviews that potentially competent midwives are discontinued because of poor academic writing skills. There was only limited evidence to support this suggestion. Others suggested that unsuitable students might "get through" and register as midwives. However, the majority of students in the study cohort were described by assessors, midwives, managers and supervisors of midwives as being or having the potential to be good midwives. Indeed at least one sixth of the cohort appeared to be exceptionally good, as illustrated below:

> *"I've spoken to patients who she looked after, who absolutely adored her and felt she was wonderful and I don't doubt for one minute that that she was anything other than that .... when you talk to her, she's very confident, when you talk about work, like most committed midwives, there's a kind of, I don't know, it's a shining light I don't know what it is, but when you talk to someone who's committed you feel it" (supervisor of midwives)*

> *"She's had a lot of responsibility this last sort of four or five months, which she's coped with admirably. She does give an awful lot of herself to her mums" (supervisor of midwives)*

> *"I was probably one of the most sceptical people about pre-registration students coming out .... got to be honest .....but she is really a very good and competent midwife .... she's got lots of common sense and .... she settled down very quickly into her role .... [She] has developed way and beyond what I thought people who've gone through that training course would have achieved, but I have to say I'm very impressed with her" (supervisor of midwives)*

Although quite a number of study midwives needed to build their confidence, and did so, during the first six months to a year following qualification, reservations were only raised about three midwives. These reservations were expressed by assessors and experienced midwives working with them. For the purposes of this report, these midwives are referred to as borderline students. In any programme of professional training, there are always going to be individuals who reach the end of their programme and are described as borderline. An evaluation report such as this, particularly as it is concerned with assessment of competence, needs to consider such cases and examine the processes involved in them becoming eligible to register as midwives. Quality control in professional training means that any borderline student must be considered as someone who could potentially fail the programme, and failure in professional training tends to be a complex and difficult issue to address (Ilott, 1994). The three borderline students in this instance came from three separate institutions, representing diploma and degree level programmes.

The three case studies which follow have been created from data taken from student records (including biographical details), assessment records, interviews with students (as students and practitioners), assessors, midwives, managers and supervisors of midwives and members of Boards of Examiners. In keeping with the project's ethical guidelines, very little background information is given about the individuals, so as to protect their anonymity.

9.2 Vignettes of three case study students

9.2.1 Student A

Teachers reported from the start that Student A struggled with the theoretical components and that her academic ability was not up to the standard expected on entry to the programme. She needed a lot of support from tutors and had trouble synthesising information and applying it to practice. She had only managed borderline passes in assignments and these were often at the second attempt.

Problems in practice

In the first year, student A performed at the level expected. By the second year of the programme, her practice placement assessors did not believe that she had made sufficient progress given the learning opportunities provided. Dexterity and speed were problems and student A had difficulty disseminating information to women and communicating with them. She had big problems managing her time and appeared to lack the ability to prioritise.

She also had problems making decisions and appeared to have problems using theory in practice, responding to situations without appropriate recognition of situation variables. One incident occurred where she had not reported a deviation from normal that she had discovered, and her assessor was concerned that she might not be able to take appropriate action or recognise the limits of her capability. She was also limited in her ability to provide individualised care in terms of planning, according to her assessor, and was lacking confidence and initiative in the implementation stage.

Following intervention by teachers, some progress was made but student A's performance was described as inconsistent:

> *".. The [assessor] actually felt that the girl made significant progress, but it was very much a question of was she having a good day or a bad day, because when she had a bad day it was very bad, when she had a good day, it was rather better." (Teacher)*

Teachers were also concerned that she could have achieved all outcomes in some areas but not the same outcomes in other areas and it is not clear whether this occurred because of assessor discrepancies or because student A had problems transferring abilities across contexts. It was suggested, in addition, that she missed out on management aspects as she spent so much time trying to improve areas of weakness. One assessor felt it might have been better to discuss with student A the idea of discontinuing the course while another suggested that she should have an extension to her clinical practice allocation.

Personal characteristics

Student A was described by teachers and assessors in very positive terms as very caring and motivated towards midwifery. Assessors stated that the women and staff liked her. Initially she appeared to have problems dealing with individuals from a different background to her own (women and staff) and to assessors she seemed awkward in women's homes. Her assessors also suggested that she had problems with individuals seen as authority figures. Negative feedback on her performance, to which she also reacted defensively, tended to shake her confidence.

Pattern of events related to decision to pass student A

It is possible that problems in the clinical area could have been picked up in the second year had there been better continuity of assessors. Student A had various assessors and the assessor who made the final decisions about her had not worked with her for many weeks and may have given her the benefit of the doubt. Teachers were aware that she was having problems because of what assessors had said to teachers or had alluded to in the comments section of her profiles. However, teachers were lacking evidence because some listed competencies had been recorded as being achieved despite comments that her care was not up to the standard expected of students at that stage.

> *"... there have been reports from the clinical area that concerned us, but unfortunately they were verbal comments, and when they got the written documentation, the girl had attained her performance criteria, there was nothing written down, even when we follow, well there seems to be some improvement. ... There was one particular instance, .. she had attained all of her performance criteria, she had achieved the core outcomes and the performance criteria, but a give away comment at the end said this student does not seem to be performing at the level that I would expect." (Teacher)*

Although problems had been highlighted early on in the programme, subsequent reports from the same assessor suggested that she had improved and she was "very pleased with the way she has progressed".

Action was only taken in the third year when an assessor who was concerned about student A called in a teacher to be involved in making the decision. The assessor felt that, although progress had been made, student A had still not reached the appropriate level for the stage of the programme and needed to develop her midwifery skills and to gain management experience. She was lacking confidence and needed guidance to use theory in practice. The teacher involved, who also made an assessment, agreed with the assessor and the decision was made to extend student A's time in this particular area. What had puzzled another teacher was that student A had achieved outcomes in one area but did not appear able to transfer this learning in another area of midwifery practice.

A few teachers were concerned at the possibility that there might be a deficiency in the assessment strategy as, had the assessor in the third year not gone to the school, the extent of student A's problems may not have been highlighted. Following the extended period, student A had still not achieved all of her competencies. For a variety of reasons another extension to the programme was provided, at the end of which student A achieved all requirements for eligibility to register on part 10 of the professional register.

9.2.2 Student B

Student B appeared to have weaknesses in both theory and practice but these were not obvious until the last part of the programme. She had had average grades for all assignments in the first and second year but failed two of the third year assignments at the second attempt. The Board of Examiners gave her the chance to repeat these assignments and, once successful, she was passed as eligible to register. Problems in practice were not evident from discussions with teachers, the student or from her personal profile. It was not until one of student B's assessors was interviewed by a member of the project team that details of problems in practice came to light.

Problems in practice

The assessor also felt student B was slow and not able to plan her work or prioritise. She felt she was anxious, did not believe in her own ability and was lacking practical experience. She could not manage to care for more than one or two women at a time and was unaware of "the obstacles that may be created by her bad planning".

The assessor also felt that student B would have difficulty fulfilling many of the UKCC outcomes although from the assessment in practice profile, other midwife assessors had signed to say they had been achieved.

Discussion of the decision to pass her

A key question in this case is - how did student B pass the programme when there appears to be evidence that she did not appear, to one assessor with whom she had worked quite a lot, to be adequately prepared to fulfill the role of the midwife?

The evidence suggests that one assessor could have failed student B in practice but did not. It appears that the assessor had difficulty with the assessment profiles and perhaps did not fully understand them. As student B had already been documented as having achieved all outcomes by another assessor in a different context, the last assessor did not feel that she could then record her disagreement in the assessment documents. However, the option was there for her to make comments which she did. Unfortunately, these comments were not very explicit and did not reflect the gravity of her concerns and no action was taken by the teachers.

During the interview with this assessor, she felt that she had been poorly prepared for her role and did not fully understand the assessment documentation. However, she did go and talk to one of the teachers but there are no records of those discussions. In the final assessment there is a comment by a teacher which suggests that she would have liked to have seen details of their discussions recorded.

There are several possibilities raised as to why student B was not failed in practice. One possibility may be that the assessor did not want to fail student B and felt that she could talk more openly to the project researcher as the things she said to her would not influence her progress to being a midwife. It is clear that she liked student B and she pointed out in her profile that she was a caring person.

A second possibility is that the teachers were aware of the problems that student B was having but lacked clear evidence to fail her as assessors had not made their reservations about her ability clear in the assessment records. This was alluded to in the teacher's final comment written in the student's profile.

The assessor that we interviewed felt she had been poorly prepared to use the assessment profiles and may not have understood that she could have voiced her disagreement with a previous assessor's statement in the documentation that student B was capable. However, it is also possible that the documentation was too inflexible to be able to accommodate such multiple assessments in similar areas of practice.

9.2.3 Student C

Student C performed very well academically and there is no doubt that she had a very good knowledge base at the end of the first year in practice. However, there were suggestions that she had some difficulty using this knowledge in practice. Although her assessors passed her as competent, there is evidence that she was having some difficulty prioritising, planning and taking action on her own responsibility.

> *"She's like brilliant on theory, but sometimes the practical things, she doesn't realise that things have got to be done ...." (assessor)*

From the assessor interview, it appears that these problems were probably resolved by the end of the programme. However, in the light of phase two data - following the students up as midwives during the first year in practice, it appears that she continued to have such problems to the end of the first year in practice.

> *".. as providing care for each individual person she had developed well, but as I say she was still finding it difficult to see the whole picture because as a midwife you have to look after everybody on your ward."(midwife)*

The only doubts expressed by teachers in phase one of the project were that she had some problems when it came to achieving her competencies. This may well relate to a personality conflict that student C reported and when this resulted in a failed assessment, student C resolved it by getting another assessor to repeat the assessment so that the outcome was satisfactory.

9.2.4 Their first year in practice

Further data was collected about two of these borderline students for a full year following their registration as midwives.

One of the midwives referred to in the vignettes worked in a variety of Trusts with virtually no support or supervision for the first six months. During the second half of the first year she was based in one Trust only. Because of the frequent changes of location, the only feedback received about her during the early months was that she was a nice person who just got on with her work. The picture at the end of the second six months was somewhat different. Her supervisor of midwives (who was also the midwifery manager) felt that this study midwife had needed a lot of support. She mentioned an incident that was drawn to her attention by staff on the labour ward. They had not realised how little labour ward experience the study midwife had been given since qualifying and allocated her to caring for a high dependency pregnant woman. She was clearly out of her depth but did not ask for help or recognise what she did not know. The supervisor of midwives felt that after an extended period of time on labour ward the study midwife demonstrated capability in caring for normal midwifery cases and had sound knowledge. However she still struggled in terms of management and prioritising care, and lacked experience of caring for women with complications. She felt that this study midwife had not been given the opportunity to consolidate her training in the first six months following registration.

The other midwife appeared to be given quite a lot of support in her first year as a practising midwife. She was also described as having a very good knowledge base and capable of providing care on a one-to-one basis. However both the midwife she worked with and the study midwife's supervisor of midwives felt her progress was slow and she lacked confidence. The supervisor stated that she had serious reservations about this midwife. At the end of a year she was still having problems prioritising, managing a caseload and keeping good records. Advice and constructive criticism given by senior midwives did not appear to have been taken in and the supervisor did not feel that she could rely on this midwife to detect deviations from normal. The supervisor felt that some day this study midwife would be a good midwife but that day was still a reasonably long way away.

9.3 Discussion and Conclusions

Taking a closer look at these three borderline students has been useful in the evaluation of current assessment strategies and has raised some interesting questions, such as: Should these students have passed? Is the assessment process rigorous enough? Should there be a borderline status in professional education? One issue raised in focus group work on the assessment strategy (Chapter 10) was the emphasis on knowledge and clinical ability and neglect of the softer elements of competence such as attitudes and personality. The analysis of data for these three students demonstrated the effect of attitudes and personal qualities on outcomes. In one profile there were several comments about difficult personality issues. In the other two profiles students were described as "nice" or "caring" but there were also comments about them sometimes having difficulties with interpersonal communications.

The most important issue in all three cases appeared to be that teachers and Boards of Examiners lacked sufficient evidence from practice assessment records about the capability of these students to practise as midwives. This occurred even though midwives had shared their concerns about students verbally with teachers. However, they had not documented these concerns or even the fact that they had had discussions with teachers. One assessor, (who had not been involved with any of these three case study students) gave a clue as to why some comments made in assessment profiles were not very explicit :

> *"In fairness it is not easy for some people to say "Look, this girl is not achieving, she has problems". It is easier to write down - "she's reasonable". And then the unfortunate girl gets at the end of the day .... being told that she's not particularly good". (Assessor)*

Some assessors may feel that they are responsible for the student not achieving or that the student's failure will reflect poorly on them:

> *"We're quite conscious of our vicarious responsibility in the fact that if the student doesn't do well, it does reflect to a certain extent on the [assessor] that there are perhaps things that we should have picked up that we didn't if there's a problem. So there is an element of quite a strong responsibility there". (Assessor)*

Assessors who are not confident to assess may possibly be more inclined to give a student the benefit of the doubt. In the same way as one of the student's assessors did not feel adequately prepared to assess, another assessor, at the same site, pointed out the importance of adequate preparation:

> *"you know I could have prevented her from qualifying through what I wrote in her assessment, so they are asking us to make decisions about whether someone should enter into our midwifery profession, and I don't think you should do that to someone who hasn't had quite a lot of training, ... just two day mentor assessor skills I don't think is enough personally". (Assessor)*

Assessors may find it difficult to fail a student particularly if they become very friendly with them or if they find that students have very good personal qualities. The difficulties involved in having to fail a student were mentioned by a few assessors; and reflect those reported in many other areas of professional education

(Ilott and Murphy, 1997):

> *"it's difficult to be, you know if you become friendly with the person and things aren't going right, to detach yourself from that friendship you may have formed" (Assessor)*
>
> *" if you have a midwife that isn't making the grade for whatever reason, some people feel very threatened if they write something down. Will they judge her, as the girl's mentor, as not having achieved this girl's aim. And then they feel very threatened as well because maybe people will think she'll go away and say to her friends "Oh she was rotten, she gave me a rotten assessment" or whatever and people like to be liked. But I think that sometimes people don't realise that they're not doing them any favours". (Assessor)*

Another issue concerns the amount of support which is appropriate for teachers to give students to enable them to pass assignments. One student suggested that teachers may well be more supportive than they should be and are prepared to correct numerous draft assignments before the final version is submitted.

This may be particularly pertinent considering students who are not failed early in the programme but get to the end. At this stage it may be very difficult to come to terms with having to fail a student. Teachers may feel a sense of responsibility towards the student and this may conflict with their responsibility to protect the public from practitioners who are less than capable.

Making a judgement about the appropriateness to 'pass' these borderline students, in the light of data one year after qualification, is difficult. We can only make our judgement on the basis of what interviewees have told us and as such our data carry all sorts of biases. Data suggest that two of these study midwives appeared to be behind their colleagues in terms of progress. Both were lacking in confidence, were not always able to recognise deviations from normal or prepared to ask for assistance when required. However, in terms of providing good quality care on a one-to-one basis where everything is normal, they appear to be able to cope very well. It is arguable that they have been prepared to work as competent midwives but within a different environment to the one in which they found themselves.

> *"... one of the main problems ..... was that .... the course was a very idealistic one and the move towards community based care team midwifery and continuity of care were being talked about at the time it was planned but was still very tentative, but the course was planned round the belief that by the time the first practitioners were coming off the course these things would already be up and running, and that didn't happen" (teacher)*

> *"No matter how much .... every student when she ..... every applicant when they come for interview says that they see themselves being the community midwife giving holistic care; that in actual fact is not yet the reality for the majority of mothers, let alone say midwives. And I think they do need, they do need a lot of help in learning how to handle more than one mother at a time .... and the needs of the various team members. That without a doubt, is the reality". (teacher)*

A dilemma seems to exist where some institutions take the best qualifiers as midwife practitioners, often leaving those most vulnerable and most in need of post-registration support and advice to seek employment elsewhere. These new qualifiers sometimes experienced delays in gaining regular employment, and hence a drop in confidence and abilities before being given the opportunity to consolidate what they have learned as students. However, there was an exception to this trend where the manager felt obliged to give the midwife a contract of employment and good support because she had trained locally. Where this does not happen, students who have been given tremendous support to enable them to complete their midwifery programme must feel abandoned by the system at the point when they become qualified if immediate employment or support are not forthcoming.

Key Issues

- Failing a student in practice placements is difficult for a 'caring' profession (9.2.1, 9.2.2, 9.3)

- Where there is insufficient assessment evidence, the benefit of the doubt is in the student's favour (9.2.1, 9.3)

- Teachers are not always made aware of problems in relation to students in practice placements (9.2.1, 9.2.2, 9.2.3, 9.3)

- Assessors can be reluctant to refer or fail a student if they:

    - have had poor preparation for their role (9.2.2, 9.3)

    - lack confidence in making judgements themselves coupled with lack of support from teachers (9.3)

    - do not know the student very well (9.2.1)

- Assessment documents rarely require multiple sources of evidence across a variety of contexts (9.2.2, 9.3)

- Students might manipulate assessors or the system (9.2.3, 9.3)

- The programmes were effective in preparing the majority of students for their first midwifery appointment (9.1)

- Students who had previously been described as exceptionally good, later went on to become excellent midwives (9.1)

- Midwives most in need of support post-registration appeared to receive little or no preceptorship (9.2.4, 9.3)

CHAPTER 10

THE ASSESSMENT MATRIX

10.1 The need for an assessment matrix

The brief for the project included the requirement to identify and develop new tools for assessment. This aspect of the project initially caused the case study institutions some anxiety. There was resentment that once the EME project had produced its report, the ENB might impose a universal assessment strategy that took no account of individual curricula and local variations.

From our work with the case study institutions and small discussion groups at an EME conference held in May 1995, it became evident that it would not be possible or appropriate to produce 'the ideal assessment tool'. Instead, following discussion with the Steering Group, it was agreed that an assessment matrix should be developed. This matrix would then enable judgements to be made about the comprehensiveness of each institution's assessment scheme.

Developing an assessment matrix was a challenge which was welcomed by the EME team. Such a matrix should not only assist the ENB when validating and monitoring midwifery programmes, but should also provide midwife teachers with a research-based resource for curriculum development. The methods used to develop and then test the matrix are set out in the following sections.

10.2 How comprehensive is the assessment of competence currently?

Inevitably when designing and implementing new programmes there will be gaps and deficiencies in assessment. The research team is aware that many institutions are modifying their programmes in the light of experience. However this review of the comprehensiveness of assessment strategies can only draw upon the evidence presented at the time of the study.

Although curriculum documents were found to list, as one of the aims of the programmes, "to ensure that students meet statutory requirements for the role of the midwife", there is significant variation as to how institutions link these requirements to their assessment strategy. From the evidence provided it would appear that in some cases it is done very well and some of the requirements are used as the basis for learning outcomes, and for developing criteria for theoretical based assessment and practice. In other cases there is no link between assessment and statutory requirements but where statutory requirements are used they tend to be centred on Midwives Rules: rule 33 (3c) parts (i) to (xi) and generally neglect parts 2- referring to accountability and responsibility for practice (including the activities of a midwife), and 3c- referring to responsibility for professional development.

One institution was found to base its assessment around the activities of a midwife for a more holistic assessment of practice and incorporates Rule 33 and some midwifery skills to break down broad statements. In some cases UKCC Midwives Rule 33(c)(iii) - assessing, planning, implementing and evaluating care ..., is used as the framework around which the performance criteria are based.

As the Rule 33 outcomes are unpacked some strategies appear more comprehensive than others, covering most or all aspects of each outcome, whereas gaps can be seen in other strategies. In general, those covered poorly include outcomes (ix) - an understanding of the requirements of legislation ..., (x) - an understanding of the ethical issues relating to practice ..., and (xi) - the assignment of the midwife of appropriate duties to others ... . Areas of the midwife's role reported to us as poorly covered included drug administration, management, parent education and a few specific midwifery skills.

From this evidence it is apparent that there were considerable variations in the comprehensiveness and emphases in assessment adopted by the different institutions. Given these variations, it was clear that we needed to consult more widely to find an assessment matrix that would be appropriate and acceptable for national use.

10.3 The use of questionnaires

The establishment by the ENB of a Professional Midwifery Advisory Network (PMAN) provided the EME team with an ideal group of experts with which to consult. A questionnaire (Appendix 8b) was constructed from data obtained from midwifery curricula, interviews and brain storming sessions with midwives and student groups, plus group work with a convenience sample of parents (Fraser, Murphy and Worth-Butler 1996). There was a 75% response to the questionnaire sent out to 54 PMAN members and 6 ENB Midwifery Education Officers. The findings were presented to members of PMAN who then participated in small group discussions to identify and help to clarify important assessment issues. A more detailed discussion of this aspect of the study can be found in Appendix 8 (summary of Worth-Butler, Fraser and Murphy, 1996).

A synthesis of assessment data identified the importance of constructing an assessment scheme which encapsulated the role of the midwife fully but was realistic about mastery at the point of registration. There was a consistent view that a National Vocational Qualification approach fails to capture the complexity in which a midwife operates and that a more holistic approach to assessment is needed. However, there was also concern that some assessment terminology is too broad and ambiguous to provide valid and reliable evidence that all students will have achieved the knowledge, skills, confidence and attitudes necessary for competent midwifery practice.

Another important issue that emerged related to the role of context in competence. Midwives need to be able to carry out their role over a variety of situations, and in terms of assessment a student may be competent in one situation but not necessarily in another situation. Similarly, the capability needed for the role of the midwife may vary from context to context. Many assessment schemes were seen to address this by arranging areas or elements to be assessed into three contexts: pre-conception/antenatal care, care in labour and postnatal care. These three contexts were used as the basis for discussion papers sent out prior to work with focus groups.

10.4 The use of Focus Groups

Each of the six case study institutions agreed to host focus groups for the EME team. In issuing invitations we tried to include all those groups involved in assessment of student midwives. The participants represented midwife teachers, supervisors of midwives, midwife assessors, current three-year and shortened programme student midwives and our case study students (now practising midwives). On average there were eight people present for most of the focus group days. The focus group participants were asked to help the project team develop an assessment matrix by doing the following:

- reading and making comments on our first draft of elements to be assessed
- considering how and where each element should be assessed

- raising important issues which had been omitted or needed changing
- providing a critical forum in which all opinions are valued
- reassuring us about the value of an assessment matrix.

We did not expect the focus group days to provide us with an agreed framework for the matrix, but what did emerge were differences of opinion about using the three contexts as the framework. Other important issues to emerge mirrored findings from work with PMAN members. In particular these were:

- to use broad but clear statements for assessing the holistic role of the midwife
- to break down these statements into aspects that can be assessed, but avoid lists of tasks
- to identify the context that will provide a valid assessment for midwifery competence
- to avoid a "belt and braces" approach to assessment
- to include an assessment of personal qualities and attitudes
- to avoid "jargon" and ambiguous statements.

Following the six focus group days, members of the research team independently reviewed the data obtained. Revised wording for the areas of assessment was then agreed, based on this data. The next stage was to produce a draft of an appropriate matrix to identify how each area of competence could be assessed most effectively.

10.5 Producing and testing the matrix

Having established that using the three contexts, of pre-conception/antenatal care, care in labour and postnatal care as a framework for the matrix would not be suitable, an alternative was necessary. Whilst the UKCC Midwives Rule 33 (UKCC 1993), the Activities of a Midwife (EC 1980) and recommendations for midwives in Changing Childbirth (DoH 1993) all have to be encompassed, none were supported as providing the ideal framework. The way in which the National Council for Vocational Qualifications uses broad units of competence broken down into specific elements and performance criteria might be favoured by some employers but its rigid and fragmented structure is unlikely to be able to reflect the holistic nature of the role of the midwife. The ENB 10 Key Characteristics (Appendix 9) have proved a useful framework for registered practitioners to plan their continuing education needs but would not be specific enough to use as a comprehensive framework to assess competence for midwifery practice. Another researched multi-professional system for self-assessment, called Skills Workout (Dunn and Doughty 1993), divides areas for assessment into six sections but like the 10 Key Characteristics it lacks specificity and in particular cannot capture the unique relationship a midwife needs to have to work in partnership with childbearing women.

Midwifery curriculum documents, whilst all having broadly similar curricula intentions, have very different frameworks for assessment. Some rely heavily on the UKCC Rule 33 outcomes (i) to (xi) whereas others adopt a subjective theme and some use a system similar to that of Dunn and Doughty or the ENB 10 Key Characteristics. As the tentative model of a competent midwife appeared to have been well received by the profession, following presentations at conferences in 1995 and 1996, it was decided to test it out as a suitable framework for the assessment matrix.

Independently, midwife members of the research team placed the previously agreed areas for assessment into one of the three dimensions of the model of a competent midwife. This double blind exercise demonstrated consistency and there were no areas that failed to be categorised into the framework. Data from the project as a whole was drawn upon to break down the areas in each dimension into evidence for assessment and identify the most essential and possible contexts to carry out assessments.

Testing of the draft matrix was undertaken in three ways as follows:

- presentation and discussion at Research in Midwifery Conference (April 1996)
- critical review by a midwifery education institution, involving teachers, practitioners and students
- cross-checking against midwifery curricula assessment schemes and case study students' competence in their first job
- comparing the competence dimension and areas of competence with studies which explored parents' views and experiences (Appendix 9).

No contradictory evidence has been presented to us nor has any been found in the literature. The final, proposed matrix for assessment of competence as a registered midwife is presented at the end of this chapter.

It can be seen from this matrix that each area of assessment integrates theory and practice. It requires evidence of underpinning knowledge, understanding and how it is incorporated into practice. There are certain areas of competence that are seen to be so important that they are identified as essential for assessment in different situations. In developing the matrix it was recognised that different universities impose different requirements for evidence to determine fitness for their award. It has been outside the scope of this project to attempt to distinguish between diploma and degree level standards, although no obvious differences were identified. Finding a universally accepted distinction between these standards has been found by others to be difficult (HEQC 1996) and in 1997 the ENB will be commissioning a large project to further knowledge in this field. Instead the measure has been the standard required for contemporary midwifery practice in a changing childbirth context. The independent midwife option for newly registered practitioners has been incorporated and the unreal and inappropriate expectations of some employers for an expert practitioner and ward manager have been rejected.

Whilst the brief for the project was to develop tools for the assessment of the outcomes of midwifery programmes, we believe that the matrix has a value beyond registration. Many midwives have in the past worked predominantly in one setting but are now being expected to change their work patterns to meet the recommendations in Changing Childbirth (DoH 1993). The matrix might provide them with a relevant tool to assess and identify their areas of particular expertise and deficits in conjunction with the ENB Framework (see page iv), thus enabling them to prepare for midwifery practice in less familiar contexts.

Producing an assessment matrix is however only part of a strategy for ensuring effective assessment in pre-registration midwifery programmes. Other elements include the robustness of the institution's assessment scheme as a whole, the selection, preparation and monitoring of assessors and the partnership between student, teacher and practice placement assessors. We are aware that assessment in higher education is currently subject to all sorts of pressures for reform and improved quality assurance, and assessment in midwifery education will need to change in line with such developments during the next few years (Silver, 1995; HEQC, 1996; Atkins, Beattie and Dockrell, 1993).

Key Issues

- An assessment matrix must be realistic in terms of student capability at the point of registration (10.5, Appendix 8)
- An assessment matrix provides a framework to judge the comprehensiveness of assessment schemes (10.5, Appendix 8)
- An assessment matrix based upon documentary and research evidence can assist in curriculum development and avoid duplication of resources (10.2, 10.3, 10.4,10.5)
- There needs to be partnership in learning and assessment involving students, assessors and teachers (Appendix 8)
- An assessment matrix can be used by midwives to assist in the identification of their ongoing learning/updating needs (10.5)
- An assessment tool must be comprehensive, jargon-free, avoid ambiguous statements, include underpinning knowledge, avoid a mere listing of tasks and demonstrate the integration of theory and practice (10.3, 10.4)

10.6 The Assessment Matrix

ASSESSMENT MATRIX : MIDWIFERY COMPETENCE

Cross-references	COMPETENCE DIMENSION: Professional/Friend					
	Area of competence expected at point of registration		Evidence to demonstrate capability	Most likely context for assessment		
				Practice setting	Education environment	Simulation
CC	1	Has a friendly, caring approach to women and can make them feel comfortable in any context	1.1 personal qualities	Essential	Possible	Possible
			1.2 attitudes	Essential	Possible	Possible
(vi) (viii)	2	Communicates with women and their partners, as a professional & / or friend according to context	2.1 supportive / reassuring	Essential		Possible
			2.2 giving advice / guidance	Essential		Possible
			2.3 involves other team members	Essential	Possible	
			2.4 use of records	Essential		
CC Code (13) (vii)	3	Respects the woman's right to choose/empowers women to be in control and involved in their care	3.1 uses literature & research	Possible	Possible	
			3.2 explores woman's preferences	Essential		
			3.3 explains protocols	Possible	Possible	
			3.4 seeks permission from woman before acting	Essential		
EC (ix) Code (42) (vii)	4	Understands and practises within the legislation governing midwifery practice, including keeping thorough and contemporaneous records	4.1 keeps accurate and detailed records	Essential	Possible	
			4.2 knowledge and understanding of Midwives Rules and other relevant legislation	Possible	Possible	
			4.3 knowledge and understanding of local requirements arising from legislation	Possible	Possible	

KEY

CC = Changing Childbirth (DOH 1993)
EC = Activities of a Midwife (80/155/EEC Article 4)
33 ( ) = UKCC Rule 33. (2) or (3c)
(i)-(xi) = UKCC Rule 33 3c outcomes
Code ( ) = Midwife's Code of Practice (paragraph)

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Cross-references	COMPETENCE DIMENSION: **Professional/Friend**				
	Area of competence expected at point of registration	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education environment	Simulation
CC (vii) (x) Code (13)	5 Reflects upon midwifery practice, uses relevant literature, research and ethical principles to inform decision making with the mother	5.1 demonstrates critical analysis of research and literature	Possible	Essential	
		5.2 conversant with ethical principles	Possible	Essential	
		5.3 self-assesses performance & suggests ways to improve	Essential	Essential	
		5.4 participates in evaluation of care	Essential	Possible	Possible
33(2) 33(3c)	6 Can prioritise, make decisions and manage own time in the provision of care in all midwifery contexts	6.1 caring for one person	Essential	Possible	
		6.2 participating in care of a small number of women	Essential	Possible	
		6.3 organises / prioritises own work	Essential	Possible	Possible
CC 33(2) 33(3c) (iii) (iv) (vii)	7 Demonstrates the potential to take on the role and responsibility of the lead professional when pregnancy and childbirth is normal	7.1 understands accountability	Possible	Essential	
		7.2 understands autonomous midwifery practice	Possible	Essential	
		7.3 aware of scope of own ability/own limitations	Essential		
		7.4 seeks advice appropriately	Essential	Possible	

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(i)-(xi) = UKCC Rule 33 3c outcomes
Code ( ) = Midwife's Code of Practice (paragraph)

Cross-references	COMPETENCE DIMENSION: **Professional/Friend**					
	Area of competence expected at point of registration		Evidence to demonstrate capability	Most likely context for assessment		
				Practice setting	Education environment	Simulation
(viii)	8	Works as part of multi-professional teams in the provision of maternity care	8.1 aware of role and responsibilities of others	Possible	Possible	Possible
			8.2 understands need to be woman's advocate if necessary	Possible	Possible	Possible
			8.3 pleasant, works in harmony with others	Essential	Possible	
			8.4 communicates and transfers information between team members	Essential	Possible	
			8.5 adaptable	Essential		Possible
(xi) 33(2)	9	Understands what aspects of midwifery care can be assigned to others and own responsibility for supervising that care	9.1 appropriate delegation of tasks to others	Possible	Possible	Possible
			9.2 gives clear instructions and feedback to others	Possible	Possible	Possible
			9.3 monitors care given by others	Possible		Possible
33(3c) (iv) (vii)	10	Demonstrates initiative in creating learning opportunities and meeting own learning needs	10.1 self awareness	Possible	Possible	
			10.2 questioning	Essential	Essential	
			10.3 commitment to life long learning	Possible	Possible	
			10.4 problem solving skills	Possible	Essential	Possible

KEY

CC = Changing Childbirth (DOH 1993)
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Code ( ) = Midwife's Code of Practice (paragraph)

Cross-references	COMPETENCE DIMENSION: Individualised Approach				
	Area of competence expected at point of registration	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education environment	Simulation
CC (iii) (vii)	1 Provides women and their partners with appropriate information to facilitate informed choice of care/carers	1.1 knows available sources of information	Possible	Essential	
		1.2 selects and provides relevant information	Essential	Possible	Possible
		1.3 communicates at appropriate level	Essential		
		1.4 keeps women up to date with progress and options for care	Essential		
(i)	2 Has knowledge and understanding of factors which may influence women and their families taking up antenatal care and health promotion opportunities	2.1 social factors	Possible	Essential	
		2.2 political factors	Possible	Essential	
		2.3 cultural factors	Possible	Essential	
		2.4 medical factors	Possible	Essential	
		2.5 previous pregnancies	Possible	Essential	
(i) (ii) (iii)	3 Recognises the unique needs of each woman, and involves her and her partner in discussion and decisions about her care	3.1 psychological needs	Essential	Possible	Possible
		3.2 physical needs	Essential	Possible	Possible
		3.3 educational/parenting needs	Essential	Possible	Possible
		3.4 social needs	Essential	Possible	Possible
		3.5 spiritual needs	Essential	Possible	Possible

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EC	=	Activities of a Midwife (80/155/EEC Article 4)
33 ( )	=	UKCC Rule 33, (2) or (3c)
(i)-(xi)	=	UKCC Rule 33 3c outcomes
Code ( )	=	Midwife's Code of Practice (paragraph)

Cross-references	COMPETENCE DIMENSION: **Individualised Approach**				
	Area of competence expected at point of registration	**Evidence to demonstrate capability**	**Most likely context for assessment**		
			Practice setting	**Education environment**	**Simulation**
(ii) (iii) (vii) (viii) CC	4 **Assesses, plans, provides and evaluates care in partnership with the woman during pregnancy, labour and the postnatal period**	**4.1 women's wishes**	**Essential**		
		4.2 use of relevant knowledge / research	**Essential**		
		4.3 involves others as necessary	**Essential**		
		4.4 when childbirth is normal	**Essential**	**Essential**	
		4.5 when there are risk factors / problems	**Essential**	**Essential**	
		4.6 women's advocate	**Essential**	**Essential**	

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33 ( ) = UKCC Rule 33, (2) or (3c)
(i)-(xi) = UKCC Rule 33 3c outcomes
Code ( ) = Midwife's Code of Practice (paragraph)

Cross-references	COMPETENCE DIMENSION: **Clinical Competence**				
	Area of competence expected at point of registration	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education environment	Simulation
(vi) (xi)	1 Communicates with women and their partners using methods appropriately	1.1 listening skills	Essential		Possible
		1.2 responding to verbal / non-verbal cues	Essential		Possible
		1.3 counselling skills	Possible		Possible
		1.4 report writing	Essential		
EC 33(3c) (iii)	2 Demonstrates ability to provide programmes of preparation for a healthy pregnancy, childbirth and parenthood	2.1 family planning knowledge	Possible	Essential	
		2.2 pre-conception care	Limited opps	Essential	
		2.3 sexual health and well-woman issues		Essential	
		2.4 one-to-one teaching skills	Essential	Possible	Possible
		2.5 principles of group work	Possible	Essential	Possible
		2.6 teaching parenting skills	Essential		
EC	3 Understands how pregnancy may be diagnosed and expected date of delivery calculated	3.1 signs and symptoms	Possible	Essential	
		3.2 pregnancy tests	Possible	Possible	Possible
		3.3 calculation of EDD	Essential	Possible	
EC (iii) (vii)	4 Assesses and monitors maternal and fetal well-being antenatally in hospital and community settings	4.1 use of appropriate methods	Essential	Possible	Possible
		4.2 knowledge of tests & indications for use	Possible	Essential	
		4.3 knowledge & understanding of relevant treatments	Possible	Essential	
		4.4 knowledge & recognition of normal parameters	Essential	Possible	

KEY:

CC = Changing Childbirth (DOH 1993)
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Code ( ) = Midwife's Code of Practice (paragraph)

Cross-references	COMPETENCE DIMENSION: **Clinical Competence**				
	Area of competence expected at point of registration	**Evidence to demonstrate capability**	**Most likely context for assessment**		
			Practice setting	**Education environment**	**Simulation**
EC (iii) (iv) (vi) (vii)	5 Assesses and monitors progress in labour	5.1 confirms each stage of labour	Essential	Possible	
		5.2 uses equipment/interventions appropriately	Essential	Possible	Possible
		5.3 knowledge and recognition of normal parameters	Essential	Essential	
		5.4 diagnoses deviations from normal and takes action	Possible	Essential	Possible
EC (iii) (iv) (v) (vi) (vii) Code(34-36)	6 Discusses and advises on positions and pain relief in labour	6.1 knowledge of methods and safe use	Essential	Possible	
		6.2 able to administer drugs/treatments in common use	Essential		Possible
EC (iv) (vi) (vii) (ix)	7 Takes responsibility for normal deliveries	7.1 provides a safe environment	Essential		
		7.2 knowledgeable about research	Possible	Essential	
		7.3 demonstrates dexterity	Essential		Possible
		7.4 judges whether episiotomy is necessary	Essential	Possible	
		7.5 able to carry out an episiotomy	Possible		Possible
		7.6 conducts third stage appropriately	Essential	Possible	Possible
		7.7 recognises when assistance required	Possible	Possible	
		7.8 able to respond appropriately when delivery is difficult (eg breech, shoulder dystocia)	Possible		Essential

KEY:

CC = Changing Childbirth (DOH 1993)
EC = Activities of a Midwife (80/155/EEC Article 4)
33 ( ) = UKCC Rule 33, (2) or (3c)
(i)-(xi) = UKCC Rule 33 3c outcomes
Code ( ) = Midwife's Code of Practice (paragraph)

Cross-references	COMPETENCE DIMENSION **Clinical Competence**				
	Area of competence expected at point of registration	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education environment	Simulation
EC (iii) (iv)	8 Provides for the immediate needs of the newborn baby	8.1 mother's preferences	Essential		
		8.2 examination of baby	Essential	Possible	Possible
		8.3 resuscitation	Possible	Possible	Essential
		8.4 physical needs	Essential	Possible	
		8.5 safe and secure environment	Essential	Possible	
EC (ii) (iii) (iv) (vi) (vii) (ix)	9 Assess and monitors normal progress of mothers during postnatal period and adaptation to parenthood	9.1 knowledge of normal progress and parameters of normality	Possible	Possible	
		9.2 diagnoses deviations from normal and takes action	Possible	Possible	
EC (i) (ii) (iii) (iv) (vi) (vii) (viii) (ix)	10 Assesses and monitors normal progress of baby, including integration into the family unit	10.1 knowledge of normal progress and parameters of normality	Essential	Possible	
		10.2 knowledge of infant feeding	Essential	Possible	
		10.3 support for breastfeeding	Essential	Essential	
		10.4 knowledge of screening tests	Possible	Possible	
		10.5 dexterity in carrying out screening tests	Essential		
		10.6 knowledge of voluntary agencies eg NCT	Possible	Possible	
		10.7 diagnoses deviations from normal and takes action	Possible	Possible	

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CC = Changing Childbirth (DOH 1993)
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Cross-references	COMPETENCE DIMENSION: Clinical Competence				
	Area of competence expected at point of registration	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education environment	Simulation
EC (v) (vi) (vii) (viii) (x)	11 Participates in the care of women who have complications/are "at risk"	11.1 interprets prescribed care	Possible		Possible
		11.2 carries out prescribed care	Possible		
		11.3 assists other healthcare professionals provide care	Essential		
		11.4 knowledge of complications and current management	Possible	Essential	
		11.5 knowledge of drugs	Possible	Essential	Possible
EC (iv) (v) (vi) (vii) (viii) (xi)	12 Recognises emergency situations and knows what actions are appropriate	12.1 makes accurate diagnosis	Possible	Possible	Possible
		12.2 understands degree of urgency	Possible	Possible	Possible
		12.3 knows who to call	Possible	Possible	Possible
		12.4 knows what to do before assistance arrives	Possible	Possible	Possible
		12.5 uses drugs appropriately	Possible	Essential	Possible

KEY

CC = Changing Childbirth (DOH 1993)
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CHAPTER 11

PROGRAMME EFFECTIVENESS

11.1 Introduction

The EME project brief required an evaluation of the effectiveness of three-year pre-registration midwifery programmes of education. As an outcome evaluation, the competence of midwives qualifying through this route had to be explored. In particular this involved:

(1) A comparison between actual and intended curriculum outcomes
(2) The ability of those qualifying to fulfil statutory requirements for registration as a midwife
(3) The ability of pre-registration programme midwives to meet stakeholders' expectations of a midwife at the point of registration.

These three sources of data were used, together with principles outlined in the literature on competence, to build a model of competence. Work in this area began in the early days of the project and as the project progressed, the model developed further in the light of emerging data. Those deemed to be stakeholders (Chapter 3.4), were involved in developing the model and moving it towards an assessment matrix (Chapter 10). This model formed the basis for the analysis of participants' ability to fulfil the role at registration and in their first year as practitioners.

Inevitably a major part of determining outcome effectiveness of education programmes will concentrate on the comprehensiveness and robustness of each institution's assessment strategy. This will in turn be influenced by the curriculum philosophy, framework, design and content, and hence outcomes cannot be divorced from process. This chapter addresses two broad areas, in terms of programme effectiveness identified, during the team's work with the six case study sites. As these case study sites were carefully selected using criteria to allow the study to build up a picture of pre-registration midwifery education in England, it is likely that these issues are applicable to institutions providing three-year pre-registration midwifery education nationwide.

11.2 Learning Opportunities

Chapters 5 to 7 explored the ways in which students had been facilitated or inhibited in fulfilling all aspects of the EME team model of a holistic midwife practitioner. Chapter 8 provided an insight into how much additional support students needed in order to meet employer expectation. All these data have provided an insight into ways in which programmes have proved effective or could be improved in relation to programme structure and process.

11.2.1 Individualised Approach

Evidence from all sources pointed to the effectiveness of programmes in preparing students to provide woman-centred care, in keeping with the philosophy of *Changing Childbirth*. Students were also very committed to the findings of the Health Committee of the House of Commons (HoC 1992) - known as the Winterton Report - where it was suggested that healthy childbearing women should be cared for in the community. Students were described as competent to provide care to women on a one-to-one basis when all was normal. This emphasis on one-to-one care caused problems for some students when they were expected to care for several women in a busy ward situation. Busy wards and staff shortages left some study midwives feeling disillusioned as they could not at all times meet every woman's individual needs. It is possible that encouraging students to develop the skills for problem framing and re-framing throughout the programme (Chapter 2) might have equipped them more effectively for the realities of work in the maternity service. The career aspirations of study midwives (Chapter 8.3), where very few expressed a desire to remain in hospital-based care, could in part be a result of some of this disillusionment.

11.2.2 Clinical Competence

All students achieved the minimum requirements of the EC Midwives Directive Article 27 (EC 1989 - Appendix 5). However the range of skills and activities experienced by students varied. This should not be surprising, as explored in Chapter 3, but it gave a few of the study midwives more to achieve than others in the early months following registration. It also meant that these few three year route midwives were compared unfavourably in some instances with midwives who had followed the shortened programme for registered nurses. Part of the problem lay in the differences highlighted between teachers and practitioners as to what they felt was reasonable to expect of students at the point of registration. The assessment matrix should help to clarify what is a realistic model of competence at the point of registration (Chapter 10).

Reasonable or unreasonable expectations?

Assessors, midwives, supervisors of midwives and managers frequently commented that three-year programme midwives were not as able as midwives trained through other routes to care for women who were ill, had previous medical problems or complicated pregnancies. This included not having many of the skills referred to by interviewees as 'nursing skills', such as caring for CVP lines, and knowledge of medical conditions. However, the emphasis in the curriculum was on seeing pregnancy as a normal physiological process. Accordingly, midwives should be able to provide the full range of care for normal pregnancy, be able to detect deviations from normal and take appropriate action when deviations were detected. While those interviewed who assessed students or worked with them during the first year, felt study midwives could provide the full range of normal midwifery care and almost all could be relied upon to detect deviations from normal, they felt study midwives would still need support when referring. However, with only one exception, interviewees had no doubt that study midwives could be relied upon to report such deviations to a more experienced colleague and seek advice on referral.

Practitioners interviewed frequently referred to a set of skills as those required post-registration, a finding supported by the recently published ENB study on midwives' continuing education needs (Pope 1996). These included suturing, topping up epidurals, IV cannulation, giving IV drugs and scrubbing for theatre. Although it is implied that such skills would not be expected of midwives at the point of registration, students were anxious to learn some of these skills, such as suturing, as they felt that without them they would not be able to provide holistic care for a woman.

Of more concern to quite a few midwives, assessors and supervisors of midwives was that some study midwives had not had experience in undertaking catheterisation or episiotomy prior to registration. Students were able to justify the lack of experience of episiotomy, because they said the women that they had cared for had not required an episiotomy. However, experienced practitioners were concerned that study midwives may be required to carry out one in an emergency situation and would not have someone available to advise them.

Data shows that students were reflective practitioners and were aware of their own needs for development and sought out opportunities to learn outstanding skills.

Providing more effective learning opportunities

It could be argued that if the programme had been organised differently more skills could have been learned before the programme was completed. There is evidence from assessors, midwives, supervisors of midwives and managers that many students, although very well prepared with theory, were lacking "hands on" experience. Towards the end of the programme, time which could have been used for many students to consolidate practice was often used to meet the requirements of the EC Midwives Directives (EC 1989). In some cases, students said they used flexible allocation time to gain new experiences which they had not yet had on the programme. While some interviewees wondered if the programme should be longer, others suggested that the structure of the programme was the root of the problem. In such institutions, students did not have their first experiences of clinical placements until well into the programme and, in many cases, students were there initially as observers. Curriculum designs based on the 'double-wedge' as described in Chapter 2 set out to ensure that students had the theory to apply to experience in practice placements but many students wanted to have at least basic skills which they could develop early on and could then integrate into the provision of care. Having these skills would also help them to "belong" to the midwifery profession and to "fit in" in the clinical area, a finding supported in another ENB project (Eraut et al 1995). In many cases, students experienced a lack of continuity in clinical areas as clinical days and study days were mixed together. Sometimes placements were short or midwifery allocations were broken up by non-midwifery placements so that students "would just be consolidating their practice for a short period of time and then they would move into another area".

In some institutions, this imbalance between theory and practice had been identified in programme evaluations and changes have been made to give students earlier clinical experience. Some teachers stated that they would still like to see a greater emphasis on practice in the programme but suggested that this was still some way away.

> *"I'd like to say they [theory and practice] were of equal status, they actually aren't, because the University is very stringent on the academic, the theoretical input. I believe we do put considerable value on our practice ... if you ask me sort of what, I'd have to say perhaps 60 in theory, 40 practice ..... I'd like to see them of equal value[1]. But this is a dream I've got that won't happen because it's likely to be the other way. It's just how I feel as a person and as an educationalist I believe we're producing practitioners, not theorists and when they come off they should be able to practise. Now you will find that we, we in common with other institutions aren't giving it equal value. It's a personal view." (teacher)*

> *"Pre-reg .... the main concern I have for the future is that we make it too much of an academic programme and too little of a preparation for practice." (teacher)*

Data from assessors and teachers also suggested that clinical staff needed more direction as to what was appropriate for students to learn during clinical allocations so that students' time there could be used more effectively.

Being able to consolidate practice was important to students in terms of "putting all the theory into practice" and "doing it all in one go on your own". Those students who had been able to have some degree of consolidation towards the end of the programme were able to build confidence.

> *"I feel ready to do it. I'm fed up with being a student (laugh) and I*

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[1] The ENB now requires at least 50% of curriculum hours to be spent in practice placements.

> *actually do feel ready to do it, probably largely as a result of this last clinical placement, the aim of which was to increase confidence" (student)*

In fact, one of the main difficulties that students had at registration was that they lacked confidence. They and their assessors identified the need to consolidate practice as a priority for development following registration.

11.2.3 Professional/Friend Approach

This dimension of the EME model has been left until last as it is here perhaps where there are most weaknesses in relation to learning opportunities. Chapter 5.9 demonstrates the difficulties some students had in making the transition from student to autonomous, accountable midwife practitioner. It is possible that providing learning opportunities where students are allowed "to be a midwife" in a learning context could make programmes even more effective.

Letting students "be a midwife"

Although the philosophy of *Changing Childbirth* does not encompass ward management, professional management abilities in the context of a midwifery or multi-professional team are essential requirements for competent midwifery practice. Students also found that once practising they could be expected to take charge of a busy hospital ward, irrespective of learning opportunities as a student.

Assessors, midwives, supervisors of midwives and managers provided evidence that many students were having difficulty at registration in terms of managing a caseload and ward management. However, many participants had been given little experience of management as students, even in institutions where management had been well covered in theory. While many midwives, supervisors of midwives and managers commented that three-year pre-registration students were lacking ward management ability at registration, these expectations were often based on their experiences with shortened programme midwives, most of whom would have ward management experience before entering a midwifery programme. Although it may be unrealistic to expect three-year midwives to have the same level of ability at registration, they were often treated the same. One point raised by two teachers is that the curriculum philosophy upon which case study programmes were based may have prepared students for a role in a community based service - the midwifery service of the future - when in reality, students at this point in time are more likely to start practising in the hospital where ward management skills are likely to be required.

Nonetheless, it is necessary that all midwives at registration, regardless of their programme of education, should be able to organise their own workload, as they are eligible to be independent practitioners. While some study midwives were able to manage the care of a group of women at registration and were able to manage their time well and organise their own work, this was also an area where quite a few had difficulty in their first posts as midwives. Many of those who had difficulty had not been given responsibility for a group of women as students as care tended to focus on the individual. At registration, students were required to adapt that care to caring for a group of women in the context of a busy ward. In terms of planning and managing that care, it appears that some assessors were reluctant to delegate responsibility for this aspect of care to students.

It is clear from the data that students needed to be given more responsibility towards the end of the programme in terms of being responsible for the care of a group of women so that they could develop the skills of prioritising, decision making and time management. Although most development was likely to take place with experience following qualification, students still needed more experience while they were students, where they were more likely to have the support and advice of a more experienced practitioner to hand while they develop these abilities. This was better than finding themselves "in the deep end" once they qualified. Midwives, assessors and managers working with study midwives felt some study midwives had been "cocooned" as students and then had difficulty stepping into the role of the midwife and taking on the responsibility and accountability which came with it. Better preparation of students to make that step would include them being involved more in decision making, being in charge of the ward (with support), being fully included in rostered practice and with assessors taking on a more distanced preceptor role. Students also needed more experience of communicating with and referring to other team members.

If students were given these responsibilities of 'being a midwife' other important qualities might be developed. The special relationship that many women expect to have with their midwife is only likely to develop when women feel confident about their carer. Many study midwives experienced a fall in confidence at registration which could perhaps have been reduced if more had been expected of them prior to registration.

11.3 The assessment of competence

Having established whether the pre-registration midwifery programmes provided sufficient learning opportunities for student midwives to develop competence for registration and subsequent practice, the second vital issue is to establish whether assessment was effective. Chapter 9 provided some excellent insights into assessment dilemmas and throughout the project assessment issues were frequently highlighted. These issues have been grouped into four sections as they would appear to be the most significant in terms of programme effectiveness.

11.3.1 Comprehensiveness and Appropriateness of Assessment Schemes

No evidence can be found for institutions utilising an assessment matrix, such as that described in Chapter 10, to ensure adequate depth, breadth and appropriateness of assessment schemes. The most commonly used framework for assessment was UKCC Midwives Rule 33, outcomes (i) to (xi) which fails to incorporate all aspects of the Professional/Friend dimension of competence. Student qualities were highlighted as an area of omission in assessment, particularly in the case of Student C (Chapter 9.2.3). The case study institutions sometimes appeared to have difficulties meeting the requirements of their two validating bodies, the University and the ENB.

The ENB Regulations and Guidelines Relating to Assessment require equal value and accreditation to be given to the assessment of both theory and practice. From our work with students, assessors and teachers and from observation at Boards of Examiners meetings, this would not appear to be the case. Many institutions have merged with institutions of higher education whose influence has led to an increased emphasis on theoretical assessment, and while it is always necessary for a student to be successful in assessments both in theory and in practice to be eligible to register, there appears to be a greater emphasis on theoretical assessment. This has been more difficult for institutions who have changed to a modular programme and in some cases they have felt the need to have credit rated practice assessments to compensate. Some teachers felt a high theoretical emphasis was justified as students would also qualify for diploma or degree status at the end of the programme. However a tension was apparent where such an emphasis on academic achievement, for a largely practice-based profession, could weed out students who in the view of their peers and teachers might have made good midwives. Interviewees also expressed concerns that where there was a heavy emphasis on academic assessment, this detracted from students' experiences in the practice area.

The ENB regulations also require "separate pass criteria for theory and practice" (ENB 1996, 5.7). This moves away from a philosophy of holism in assessment and from the 'principles of integration and coherence' mentioned later in the regulations. In the course of our study there have been many concerns about moves in this direction from midwives, teachers and midwifery 'experts'. Midwifery care is holistic and requires the appropriate use of theory in practice in every aspect of the role of the midwife. What appears to be more important is to determine the best context for a particular area of assessment than to test each aspect both in theory and in practice. In this regard, our work with midwifery experts raised suggestions that formative assessment could be used initially for the components of midwifery practice which could then be assessed as a whole through summative assessment. For example ability to measure and record temperature, blood pressure and pulse rate need to be assessed as being achieved satisfactorily. However, when caring for a woman, say antenatally, the student needs to be assessed as to when, where and how these tasks are performed and the results interpreted in providing individual care.

It was suggested also that many items only can be assessed in midwifery practice situations but assignment work should also make a contribution in assessing in-depth knowledge and critical analysis. However, when opportunities for assessment are limited, these need to be assessed at least in simulation. Neonatal resuscitation was offered as an important example. We have seen examples of assessments used by institutions which integrate theory with practice such as reflective diaries, case studies and assessments in practice placements using practice-based evidence and dialogue, such as that recommended in the ACE Report (Phillips et al 1994).

Our work with midwifery experts also highlighted the confusion it causes to make a divide between assessments in theory and practice. For example, the 'assessment of practice' could be interpreted simply as the assessment of a student's ability to carry out a skill or task when a student's knowledge and understanding and ability to use it in the situation also need to be assessed. It was argued that midwives test these underpinning aspects as a matter of course when assessing in the clinical area but we found variable evidence in support of this assertion.

Examinations

All assessment strategies examined in the course of the EME study included examinations although there was variation from institution to institution in terms of the emphasis placed on the number of summative assessments and examinations which students are required to complete and the format of exams (open book, unseen, known topics). In some cases, students were assessed summatively within eleven weeks of starting the programme whereas in others the first summative examination did not take place until students were half way through the programme. The ENB regulations for programmes of midwifery education require that there should be at least one unseen written examination included on the programme. While most students objected to having to sit unseen exams, many students found this form of assessment particularly useful early on in the programme for them to know that they could meet the academic standard of the programme. At least in this way, if they were likely to be discontinued from the programme, it would happen sooner rather than later.

> *"I found the exam after the first 6 months .... was important to me to know that I was reaching the standard that they wanted because I didn't know what standard I was capable of, I didn't know if I could reach that standard. That actual exam was important to me to know if I'd passed that yes, I was making the grade .... I was sort of the*

> *standard that they expected ... I think if I'd have had to wait 18 months .. that would have seemed very very hard to take and I think I would have felt very unsure of myself the whole way along." (study midwife)*

> *"There were quite a few people that left on that first exam and they realised then that they weren't up to the standard and I think 18 months is a long time to wait to find out that" (study midwife)*

Most students (including those who entered the programme with degrees) found examinations very stressful and questioned their value in making judgement on a student's ability to fulfil the role of the midwife. Students felt they could not reflect the amount of hard work they had done while on the programme, while others said they wrote what they felt examiners were looking for rather than what they would do in various situations. They felt exam questions could only focus on a very narrow area of midwifery knowledge whereas other forms of assessment, such as assignments or dissertations, could allow for the examination of a student's knowledge and understanding in far greater depth. Students said they found exams in the final year most stressful, as at this stage they had other assignments and dissertations to prepare and were intensely involved in clinical work involving rostered practice. There were suggestions put forward from students and in focus groups that studying for examinations actually detracted from practice because so much importance was placed on success in exams over success in practice. In interviews with students during their first year as practitioners, students talked about a different type of learning to that required for examination preparation and once the pressure to rote learn for examinations had ended, they could give more attention to using theory in practice.

> *"...... Awful. Just really, really stressed out and we did have a lot to do you know at the time .....working on the wards and that. I was on special care at the time so we had a case study to do. While we were on there we had the dissertation to do. We had some role play things*

> *to sort out, study days as well, you know trying to take all that information in as well as what you've already revised. I found it really, really stressful. I thought it was awful. I know I couldn't do it again" (study midwife)*

> *"I think it's just sort of as I say like everything seems to click into place .... whether it's because you're not under as much pressure as a student to know everything, when you're qualified you can sort of relax a little bit and .... things just start clicking into place ... I do feel that I've learned very much since I have qualified .... you know perhaps I was pressured into learning at the time in the class room thinking oh I've got to revise this and just trying to get it into your head without actually thinking about what it is you're learning but that might just be me the way I learn, I learn better by doing rather than reading ..... I feel a lot better this year" (study midwife)*

Students and teachers provided evidence that students could and did fail examinations because of poor examination technique rather than lack of knowledge and in some cases, students said they were given inadequate guidance on what to expect in the exam situation. Students, assessors and teachers talked about students who had been discontinued, on the basis of failure in exams, whom they felt would have made good midwives. Concern was expressed also that achievement of academic/university standards took precedence over achieving practitioner standards.

> *"The mentors have an opportunity to .... say what they think as well and from that their feelings are that this course is too academic, I'd say that's a generalisation, but one of the hospitals where we've discontinued students that they've seen as good practitioners, feel that our emphasis is too much on academia and that we're losing what could be good practitioners" (teacher)*

However, despite the negative feelings that students had about exams, teachers acknowledged that it was the only way that they could be sure that some assessed work was the students. There was however no support for an examination towards the end of the programme.

Changing assessment strategies

The pre-registration programme in its present form has only been in existence since the late 1980s and while in some cases the assessment strategies used were the result of up to 7 years development, in other cases the programme and accordingly the assessment strategy were put together in a much shorter period of time. In addition, some institutions have merged with higher education institutions and some groups of smaller colleges have amalgamated. As a result, changes were made in some cases to the curriculum and to original assessment strategies, and in a few cases changes were made during the programmes taken by individual cohorts of students. In many cases assessment review committees have been set up involving students, assessors and teachers and with their feedback and from feedback at evaluations changes were made to improve current assessment strategies. However, in one example, drastic changes were made so that a programme which appeared originally to be over-assessed in theory subsequently appeared to be under-assessed.

Overall, changes made to assessment strategies were viewed by students, teachers and assessors as improvements, but these changes were largely limited to the format of assessment and ignored important issues such as the preparation of assessors.

11.3.2 Assessment guidelines and documentation

(1) Moving to a more holistic format for practice assessment

From our examination of assessment strategies used for pre-registration midwifery education, there appears to be a move away from the original tick box approach in the assessment of practice, to assessment documents which outline a set of global outcomes. These outcomes are then broken down into assessment criteria and there were several ways in which the resulting assessment criteria were used. One way was to assess the student as having achieved or not achieved each criterion. In some cases there was an additional facility for the student to make and record a self-assessment of whether she felt she had achieved or not. In other cases students were assessed against a set of levels. These levels were described in statements placed beside each criterion or referred to a standard set of levels listed elsewhere in the document. Where levels were used students were usually expected to reach a specific level by each stage of the programme.

Generally it appeared that assessors preferred being able to state that the students had achieved or not rather than using levels. The use of levels made the process more difficult and in many cases assessors found it difficult to interpret exactly what was required in each level. Some assessors found levels inflexible, reflecting a minimum standard only, which did not allow them to reflect a student's true level of achievement.

In terms of document format, assessors liked to have adequate space to clarify their understanding of a student's ability or to comment on why a student wasn't achieving. For example, they could use the space to make it clear, if necessary, that in their view, a competency could not be assessed in their area of practice or that the student had not had sufficient experience rather than it appearing from a completed profile that a student had not achieved.

There was considerable variation between assessment strategies as to what instructions for assessment were included and in terms of requiring assessors and students to record discussions at set times during a placement. However, students found such discussions very helpful in providing them with formative feedback on their progress and direction.

(2) Ensuring accurate interpretation of what is to be assessed

While some assessors found the assessment profiles easy to use and the wording easy to interpret, there were more concerns expressed by assessors about the wording used in statements. Some were concerned that their interpretation of what was to be assessed might be different to that of other assessors. Difficulty was reported with the wording not only in some of the outcome statements used but also in statements describing levels of achievement. Wording was described as "high-falluting" and "jargon". Due to the wording, it took valuable time to interpret statements and there is evidence to suggest that sometimes the meaning of statements and what was to be assessed was negotiated between students and assessors. Where a standard profile was used for all areas it was sometimes difficult for assessors to apply statements to their specific area of practice. In a few cases some of the wording was described as inappropriate for example describing a student midwife's ability as 'excellent', or referring to activities in which a student would not have the opportunity to be involved.

These findings highlight the need to ensure that document wording is clear and unambiguous so that students, assessors and teachers are in agreement that students have achieved exactly what is required of them at each stage of assessment.

(3) Identify progression

According to the ENB (1995) Regulations and Guidelines Relating to Assessment, assessment strategies should reflect the principles of integration, coherence and progression. Although curriculum documents outlined the principles of continuity and progression in their aims for assessment, there was considerable variation as to how this occurred in practice. There was evidence from student and assessor interviews to suggest that difficulties sometimes occurred in achieving continuity between student and assessor. This may have been due to staffing problems or short clinical placements. Where problems have been noted in programme evaluations, efforts have been made to improve continuity. There was also variation between institutions in terms of how theoretical assessment was linked into the overall framework for continuous assessment.

Curriculum documents describe their assessment strategies as continuous and progressive. Theoretical assessment in the first year concentrates on knowledge of fundamental facts and principles required as a foundation of midwifery knowledge. These include sociology, psychology and biological sciences and are generally assessed in their purest forms before assessing the ability to apply them to midwifery and the parameters of normality. This is then followed in the second or third year by an assessment of understanding and recognition of and application of knowledge to deviations from normal. In some cases the final assessments in the third year included all aspects of midwifery with an emphasis on consolidation whereas in other areas the final assessments have a greater emphasis on complicated midwifery.

In practice-based assessment a similar pattern is followed with students being assessed on the basic aspects of care in the first year, moving to a more comprehensive ability to assess, plan, provide and evaluate care in normal pregnancy, to caring in complicated pregnancy as well in the third year.

There were considerable variations in the continuity offered between student and assessor in practice based assessment between institutions. This influenced how effectively completed assessment profiles reflected a student's progression and would be dependent not only on how continuously a student works with one assessor but also how the assessment profile allows details of achievement to be accessed by subsequent assessors. In some cases students used a separate profile for each practice allocation and the assessor was not given sight of previous assessments. In other cases, one document was used for a whole year (or the whole programme) and assessors could see where the student had already been assessed. Problems have been reported for both approaches. In the first approach, some placements were as short as four weeks and there was poor continuity between student and assessor. In such cases, it can be difficult to make an accurate assessment or to reflect a student's progress. In the second approach, if each outcome had only to be achieved once during that year and there was no requirement to re-assess each outcome in various contexts, a student may have been assessed as competent at the beginning of that year and in one context and not tested again, although competence may vary over time. Some strategies required each criterion to be assessed in antenatal, intra natal and postnatal contexts, but again did not always identify whether assessment is of a one-off performance or undertaken over a period of time.

The degree to which completed profiles reflect a student's progression as the programme proceeds also depends on the wording occurring in statements against which students are assessed. In some cases this did reflect progression and the wording moved from assessing principles and basic knowledge to understanding and application to normal midwifery and then to application to complicated care. While some assessment criteria were accompanied by descriptors to discriminate between performance at differing academic and professional levels, these were generally covered better in the assessment of theory than in the assessment of practice.

In the assessment of practice formative assessment was used to facilitate continuous planning to achieve and review abilities with recorded discussion at set points between summative assessments. Some guidelines stressed the importance of assessment being based on a student's competence overall and not based on a single observation or incident. Some institutions used a combination of summative and formative assessment. In some cases formative assessments were obligatory and some must be re-taken if failed.

The revised Section 5 of the ENB Regulations and Guidelines (based on the findings of the ACE Report - Phillips et al 1994) requires students to have a portfolio where all learning and outcomes of assessment will be recorded to provide cumulative information about a student's achievement and progress. We have found evidence to support the value of such a portfolio. In this way evidence on achievement from a variety of assessments can be used to judge a student's competence. We have previously raised concerns (Fraser, Murphy and Worth-Butler 1995) about students being passed as competent in an area on the basis of one assessment in one context only and in one point in time. The regulations also state that cause for concern relating to progress must be entered in the portfolio. We have heard the concern of teachers who from time to time hear doubts about a student's ability from an assessor or from another source but subsequently find that this doubt has not been recorded on assessment documents and indeed from the completed document it would appear that all is well.

11.3.3 The participants in assessment

(1) *Perceptions of assessors, students, teachers on effectiveness*

From interviews with assessors, teachers and students about their experiences of assessment, two vital features have been identified for effective assessment of practice:

(1) A clear and comprehensive document for practice-based assessment
(2) Competence in assessment.

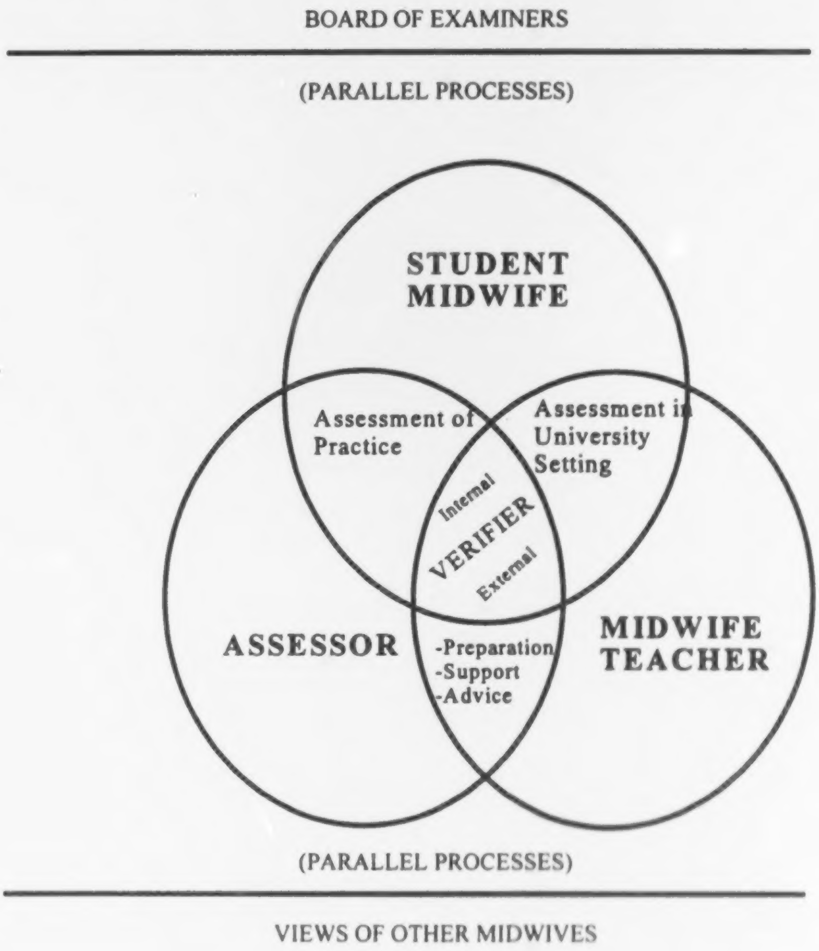
While a lot of emphasis would appear to have been placed on the first feature but a lot less on the second, the two go hand in hand. The assessment framework needs to be based around a logical format with clear wording which can be applied to the area of practice where assessment is to take place. The format of documents used must also allow assessment to be based on multiple performances across a variety of contexts, thus reflecting the need for competence to be transferable from situation to situation and across time.

In order for effective assessment to take place, assessment frameworks need to be used skillfully. Assessor preparation needs to include:

- the principles of effective assessment
- the roles and responsibilities of those involved in assessment
- what should be expected of students at different stages on the programme
- how to assess and record assessment correctly
- issues surrounding 'failing students'.

Assessors need good support from managers, so that they have time to assess and to attend assessor preparation and updating sessions, and from teachers on an ongoing basis. Teachers need to be easily contactable when problems are encountered by students or assessors but also need to be involved in the practice area in a structured way and not abdicate responsibility for assessing students in practice placements. The data supports the value of a partnership approach to assessment such as that illustrated in Figure 11.1.

Figure 11.1 **PARTNERSHIPS IN ASSESSMENT**


BOARD OF EXAMINERS
(PARALLEL PROCESSES)
STUDENT MIDWIFE
Assessment of Practice
Assessment in University Setting
Internal
VERIFIER
External
ASSESSOR
-Preparation
-Support
-Advice
MIDWIFE TEACHER
(PARALLEL PROCESSES)
VIEWS OF OTHER MIDWIVES

Assessor and student preparation also needs to be backed up with good guidelines which are readily available to anyone involved in assessment. We found considerable variation between institutions in terms of instructions for the completion of assessment profiles. Some were very comprehensive, outlining the roles and responsibilities of both student and assessor in relation to assessment, giving clear instructions about how to complete the profile and when discussion should take place, defining terms and levels and even what should happen if a student is not achieving. Others offered only minimal guidance, but this may have been supplemented when assessors attended preparation workshops.

Students, assessors and teachers were asked about the most effective way to go about assessing a student. They felt an assessor should work with a student for a sufficiently long time to be able to make judgements on the basis of what was observed during that time. The importance of discussion between student and assessor, on a regular basis, was raised, so that students had good feedback on their performance. Initial, intermediate and final discussions between students and assessors were required in some institutions and while students valued the feedback from assessors, assessors also found that these discussions gave valuable insight into a student's understanding. While student achievement was usually recorded against a set standard, being able to clarify a student's progress and record any problems encountered with written comments is also very important to provide evidence that a student has or has not achieved.

In terms of their experiences of the assessment process, some problems were highlighted by assessors and students. Many assessors reported it was time consuming to do assessment well. This was a problem as they already had a very heavy workload and clinical areas were short-staffed. In some cases the role of assessor conflicted with the role of the midwife. Where a midwife had management responsibilities, being an assessor was even more difficult.

Where there were problems in the assessment of practice, these were usually related to:

- lack of motivation of the assessor
- personality clashes/pre-existing friendships between student and assessor
- hostile attitudes towards pre-registration students
- conflict between responsibilities as an assessor and those as a midwife

- expectations not appropriate or basing assessment on comparison with other students
- assessor's own feelings of responsibility if student is not achieving.

Some students felt poorly prepared to use profiles or for the expectations that assessors would have of them. They were however expected to engage in self-assessment which appeared to have contributed to them developing as reflective practitioners and being well able to identify their own learning needs (Chapter 8).

(2) *Assessor preparation, failing students*

Our study found considerable variations between institutions in terms of how assessors were selected for their roles. In some cases a register of assessors was kept (now an ENB requirement) and midwife teachers, clinical managers and course management teams/boards of study were involved in selection. In other cases it appears that selection was less thorough, and in one case with little school involvement. Assessors were required to be first level practitioners and in most cases to have completed the ENB 997/998 course. Some institutions specified a minimum length of experience before a midwife becomes an assessor and most institutions provided specific preparation sessions with periodic updating.

Following interviews with students, assessors and teachers there is evidence that, despite the organisation of preparation sessions/workshops, all assessors did not attend. This was usually due to pressures within the clinical area although some students felt lack of motivation to being involved in assessment was in part responsible for poor preparation. Some midwives who had attended sessions still felt inadequately prepared for their role particularly in terms of what to expect of pre-registration students and how to use assessment documents. Where changes had been made to assessment strategies, some assessors had not been briefed on the changes. These assessors did not feel confident when assessing and students felt that, in some cases, the school was not aware of assessors' fitness to assess. Students also reported variations on how thoroughly assessors assessed, the styles they used and how they interpreted the wording in document statements against which students were judged.

However, there were comments about good assessors who carried out assessment well. Where students felt assessors were good, assessors drew up an initial plan with the student, observed the student working and spent time discussing issues prior to recording a student's achievement. Some assessors, when in doubt, asked the views of colleagues who had also worked with the student.

It is clear from the data that some assessors had problems failing students or recording that students were not up to the standard that they should be for the programme. However, we should point out that this was not a problem for all assessors, as such comments were seen in some of the profiles that were examined by the project team. Nonetheless, quite a few assessors talked about the possibility that in some instances where students were not up to the standard, they were given the benefit of the doubt. Some of the possible reasons for this were highlighted.

Some assessors seemed to feel responsible to some degree for the student not achieving or that they, rather than the student, would be responsible for the student being discontinued. This mirrors difficulties reported in other areas of professional training associated with the 'caring professions', and highlights the potential tension between caring for patients/clients in all circumstances whereas at times having to make definitive judgements of the competence of students in training (Ilott, 1994).

> *"I mean with the student that I've just finished with, I could have prevented her from qualifying through what I wrote in her assessment, so they're asking us to make decisions about whether someone should enter into our midwifery profession" (assessor)*

Others felt under pressure to say that the student had reached a certain level, because that was required for that stage of the programme. Some assessors said they passed students that they were not really sure about because overall the assessor felt that they were safe and that was to them the most important issue.

> *"When you're filling in you sort of feel as if you ought to be putting like ... it's got to be 3 or 4 otherwise it's detrimental to the student and yet sometimes you feel it shouldn't be like that ... you're put in a position you feel you've got to sign box 3 or 4, even if you don't feel it's quite the right area to be signing because if you don't then the student might be look, be made to look as though she's not sort of getting on very well" (assessor)*

> *"I mean I couldn't have written in her book and passed her, if I didn't think she could be safe, and I think she will be safe when she's a midwife and she's proving herself now when she's working alone that she can be safe" (assessor)*

There were suggestions also that assessors felt threatened by having to write something negative about a student. However, as a few assessors stated, assessors who did not make it clear that a student was not achieving were "doing them no favours" as the problem was only postponed to a later stage in the programme when it would be more difficult to deal with.

(3) Teacher involvement wherever assessment takes place

Although some assessors felt there was no need for more teacher involvement in practice assessment as they were perfectly capable of making decisions on a student's clinical ability, many felt there was a need for more involvement. Few had not seen any teacher involvement unless the assessor had gone to the school to report a problem. Some had experienced poor communication with the school and some students felt the school was not aware of problems they were having in the practice area. In one case an assessor had doubts about a student's ability but was unable to get in touch with a teacher and therefore gave the student the benefit of the doubt and passed her. Assessors who had difficulty with assessment documents would have liked more support in the clinical area and some students would have liked teachers to give them more support in the practice area. More involvement, it was suggested, would give teachers more insight into a student's ability and reduce the theory/practice gap experienced by some assessors and students.

From interviews with teachers and assessors, it is clear that not all problems were documented so that although teachers knew that students were having problems achieving, there was a lack of evidence in profiles for them to take action. Closer involvement for teachers with assessors in clinical areas could help to address this problem.

(4) Reliability between assessors

Another consideration in the effectiveness of assessment is the extent of variation in the expectations of assessors and their interpretations of what is to be assessed through each statement. There is evidence in a few cases to suggest that variation does occur. Some students reported assessors having very different interpretations of the meaning of statements and in some cases both students and assessors admitted that they had negotiated between them what exactly was to be assessed through various statements. In other cases students disagreed with assessments made by assessors on the basis of interpretation of the wording in profile statements and levels. On rare occasions assessors did not believe that a student could have achieved what was recorded by previous assessors on the basis of how a student was performing at that particular time. There were variations in the ways that each of these problems were resolved.

Better preparation of assessors and support from teachers in the clinical area could help to ensure that all assessors are working to the same agenda for assessment.

(5) Place of women's judgements in assessment

In the course of project work with focus groups, the possible involvement of the recipients of care in judging whether or not a student is competent was raised. Some participants felt women could provide valuable feedback on a student's ability and on the quality of her care. However, other participants were cautious about the effects that asking women to make such judgements could have on how they perceived their quality of care and on possible legal implications if women were to think that they were given care by anyone less than competent. There was evidence though that assessors did indirectly elicit the views of mothers about their student.

11.3.4 Assessment evidence

An effective assessment strategy will provide sufficient evidence for a valid judgement to be made on whether a student is competent at the point of registration. In addition, with effective assessment, students who are not likely to become competent are more likely to be weeded out early in the programme, thus saving the student and the institution time and expense. There will however always be those who are unable to integrate the dimensions of the model of competence and this is unlikely to be possible to assess unless students are given opportunities to 'be a midwife'. During the course of the study, areas have been identified where evidence is lacking about student inadequacies. Teachers then find themselves in a position where they cannot fail a student although they are aware that it is possible that the student might be unsatisfactory for autonomous, accountable practice.

(1) Lack of evidence from practice assessment

We have already given accounts of some of the reasons why some assessors do not record their doubts about a student's capability. In Chapter 9, our study of 'borderline' students identified the possibility that a student could be unsatisfactory from very early on in the programme but because different assessors defer the decision to fail them at various stages, they manage to get to the end of the programme when a decision has to be made as to whether or not they should pass. Teachers may be aware that a student has problems from informal feedback but find themselves unable to do anything about the situation because assessors have not documented their concerns. In some cases, it is possible that teachers are not even aware that there are problems.

Teachers outlined some of the situations that they were faced with because of lack of evidence from the practice area:

> *"If the students were weak, then the mentors tended to back off and see it as someone else's responsibility, and to draw those weaknesses to our attention. I think with one student who was particularly weak, we were quite lucky in that the clinical tutors of the area became involved as well and so it didn't become the mentor's responsibility, it was a dual responsibility between the mentor and the link tutor. And that seemed to overcome the difficulty. But I think when there are problems with the students, then it's very hard for the midwives"*

> *(teacher)*
>
> *"The ones that are going to be good generally get what they need, it's the ones who are not and it's the reasons why they're not that are of concern, and catching the ones who can skate around too many mentors - [one who] used to do that .. the mentor wouldn't sign the form to say she was satisfactory, and she came on one weekend to find somebody else to do it and had that person sign it, so we couldn't do anything after that" (teacher)*
>
> *".. It's actually a very very difficult situation. We did identify it earlier. We did have grave concerns really since the beginning of the course, not at interview, she actually interviewed very well, but really with the first formative exam ... there have been reports from the clinical area that concerned us, but unfortunately they were verbal comments, and when they got the written documentation, the girl had attained her performance criteria, there was nothing written down, even when we follow, well there seems to be some improvement. .... There was one particular instance, .. she had attained all of her performance criteria, she had achieved the core outcomes and the performance criteria, but a give away comment at the end said this student does not seem to be performing at the level that I would expect ... it's not written down exactly what the deficits are, we had to agree on that. [The student] said "have I achieved the core outcomes and the performance criteria", we knew we didn't have a leg to stand on" (teacher)*

In the light of these findings, it is important that assessor preparation should emphasise the need for assessors to document any concerns that they have about students and to record dealings with teachers. More efforts need to be made to remove the taboo surrounding failure and to remove personal feelings of responsibility for a student failing that assessors may have. Assessors' accountability and responsibility not only to the student but also to the profession and the public need to be stressed. The work in other disciplines by Ilott (1994) on failure and assessors involved in failing students is particularly pertinent to this part of our findings.

(2) Documents that facilitate recording of evidence

The format of documents that are used to record assessment influences the extent and quality of evidence provided about student ability. Instructions for completion can stress the importance of sufficient evidence and the form that this might take. Sections requesting specific feedback on specific areas of competence and at specific times would appear to work better than leaving assessors to make judgements about what needs to be assessed and how and where assessment should take place. Instructions and document format should also ensure that recorded summative assessments are based on multiple performances over several contexts.

(3) Areas that are not assessed or not assessed effectively

In Chapters 4, 5 and 6, we outlined student ability at the point of registration in terms of intended outcomes listed in curriculum documents. We identified areas where students/study midwives were having particular problems. Although listed in intended outcomes, for some areas we could not find sufficient evidence to suggest that they were actually assessed. These omissions were not made in every institution and some institutions had more omissions than others. However, this means that students have been passed as competent to fulfil the role of the midwife although some aspects of this role have not been assessed. This, of course, does not mean that students were not capable.

The main areas highlighted by students and assessors as being under-assessed were: - personal qualities such as attitudes; being responsible and accountable;

management skills - including organisation, time management and delegation skills; skills to participate in care for women who are ill or have complicated pregnancies; parentcraft; and the administration of drugs. These were some of the areas identified in phase 2 of the project, where study midwives had difficulty as new practitioners. It is possible that including specific areas in assessment may ensure that learning opportunities are made available to students in order to achieve the necessary competence in these areas. It seems that including an area in assessment raises it to a new level of importance to students and assessors and some might hold the view that if an item is not assessed then it must not be important.

11.4 Conclusions

The overall finding of the EME project is that the three-year pre-registration route into midwifery is an effective preparation for contemporary midwifery practice. In spite of initial prejudices held by some experienced midwife practitioners and teachers, the commitment and enthusiasm of these students towards woman-centred midwifery practice changed their views. Midwives were particularly impressed by students' knowledge and understanding of the theory underpinning midwifery practice, their reflective and questioning attitudes and wide reading and use of research.

Evidence was abundant that pre-registration route students could provide what was described as competent, normal, midwifery care to women on a one-to-one basis. There were however variations in the ability of students to make the transition from student to midwife practitioner in busy, often short-staffed maternity units. This seemed to have more to do with individual students than with programme differences. For example, although one third of study midwives had difficulty with the transition from student to midwife, most coped well but a few needed considerable encouragement and reassurance from their colleagues (5.9.1, 8.4).

On the whole, programmes were very similar in structure although some included strategies more likely to help the weaker students.

The greatest overall weaknesses were in relation to variations in learning opportunities and to inadequacies in assessment strategies. Many of these inadequacies were reduced by the good liaison between school and practice placement staff. Maternity units are also generally quite small and dialogue between practitioners about students was for the most part effective. This effective dialogue and liaison could be attributed to midwifery education and midwifery service being inextricably linked in the past and it is hoped that this will continue as the tripartite relationship between student, teacher and assessor appear vital for programme effectiveness.

From a review of the literature on professional education there is a view that competence is a continuum and we should not expect all students to reach the same point at the same time. However statutory requirements and evidence from this study would suggest that all students must achieve the components of the EME model of competence at the point of registration. Midwives, unlike many other professionals, have a licence to practise independently at the point of registration. This was perhaps an aspect of programme effectiveness that was neglected. Not all students received preceptorship and therefore programmes need to address this issue in future. It would seem essential to provide more practice based problem solving situations at a much earlier stage so that students are enabled to achieve their 'EC numbers' earlier and can use the last few months to consolidate and 'be a midwife'.

Finally, inevitably most assessment strategies have weaknesses. Improvements in preparation of assessors, teacher involvement in the process of practice-based assessment and better assessment documents and evidence should go some way to avoid the label 'borderline students?'.

What must be of concern to all those reading this report is the fate of those weaker, less confident students. Competition for jobs is such that the best will be chosen and the EME study has evidence of exceptional students exiting from these programmes and immediately being offered substantive contracts locally. This means that other students have to seek jobs away from their training site, have to work for agencies or experience delays in securing employment. Hence, those most in need of preceptorship are the least likely to receive it. The 'professional start scheme', funded for two years by NHS (E) Trent, was one good example of ensuring preceptorship was provided for all those initially unable to obtain Trust funded posts.

This study concludes that absolute programme effectiveness can only be confirmed when every student successfully completes the programme and has the capability to competently and confidently to take on the holistic role of a midwife practitioner. It is hoped that the EME Project outcomes of:

- a holistic integrated model of a competent midwife
- the assessment matrix
- guidelines for good practice in assessment

will go some way to achieving that goal.

Key Findings

- Study midwives were well prepared to provide holistic midwifery care to women with normal pregnancy and on a one-to-one basis. They had a comprehensive knowledge base, could use research in practice and had the skills to fulfil the statutory requirements (11.2.1, 11.4)

- The majority of study midwives could be relied upon to detect deviations from normal, take appropriate actions and would seek help as necessary (11.2.2)

- Some students did not have sufficient learning opportunities to enable them to achieve all the requirements for holistic midwifery practice. This might be improved through:
  - developing students' problem solving skills from the outset (11.2.1)
  - earlier practice placements and skills development (11.2)
  - simulation, if opportunities for experience are limited (11.3.1)
  - allowing students 'to be a midwife' in final weeks (11.2.3, 11.3.4)

- Assessment schemes might benefit from drawing upon an assessment matrix to ensure no gaps in assessment, to identify the best context(s) for assessment, and avoid over-assessment and unrealistic assessment (11.2.2., 11.3.1)

- Assessment schemes tended to neglect or under-assess
  - personal qualities eg attitudes (11.3.1, 11.3.4)
  - capability to assume responsibility and accountability (11.3.4)
  - management skills (11.3.4)
  - care of women who are ill/have 'special' needs (11.3.4)

  - administration of drugs (11.3.4)

- Institutions experienced difficulties reconciling university and ENB assessment requirements. Where there was too heavy an emphasis on examinations and assignments this detracted from assessment in practice placements. In addition it also appeared to result in ineffective use of learning opportunities in practice (11.3.1)

- There was a false divide between theory and practice assessment. Assessment was most effective where they were integrated and the most appropriate context for assessment of outcomes selected (11.2, 11.3.1)

- Students were not always given opportunities to demonstrate whether they could integrate the elements and dimensions of competence into holistic midwifery practice (11.3.4)

- Assessors find it difficult to fail students especially when colleagues have given a 'pass' grade previously and it is now near the end of the programme (11.3.4)

- Although midwives have a licence to practise independently at the point of registration, a small number of students appeared to have been 'given the benefit of the doubt' to register as midwives (11.3.2., 11.3.3., 11.3.4)

- Students who are unable to integrate the dimensions of competence into holistic midwifery practice should be failed even if it is at the end of the programme (11.3.4)

- There is support for use of a portfolio (ENB 1996 Section 5) to contribute to assessment decision making (11.3.2)

- Documents for assessment in practice placements were not always easy to use, they need to: (11.3.2, 11.3.3., 11.3.4)
  - use clear, unambiguous statements
  - provide clear instructions
  - provide space for students to record evidence
  - include adequate space for assessment comments
  - provide space for student/assessor/teacher dialogue

- Assessors were not always prepared or updated effectively to assess students, particularly in relation to: (11.3.3)
  - the skills that students need to acquire and develop (11.3.3)
  - the expectations of the programme in terms of knowledge, competencies and attitudes (11.2.2)
  - the emphasis on student problem solving and not an apprenticeship model (11.2.1)
  - involving students in the decision making process throughout (11.2.3)
  - giving students more responsibility towards the end of the programme (11.2.3, 11.3.4)
  - receiving clear guidelines for assessors, eg a pocket book for easy reference (11.3.3)

- Assessment decisions in practice were found to be more effective when there is good communication between education and practice and a partnership approach between student, assessor and teacher (11.3.3, 11.3.4, 11.4)

- Unseen written examinations towards the end of the course were less effective in determining fitness for practice (11.3.1)

- A period of consolidation would appear to be needed when all assessments have been completed and prior to registration as a midwife (11.2, 11.4)

- Employers did not always provide for each new midwife's learning needs (11.2.3, 11.4)

- The need for systematic evaluation was demonstrated when a major curriculum change, following a one-off evaluation, led to inadequate assessment (11.3.1)

DEVELOPMENTAL IMPLICATIONS FOR THE BOARD

1. Recruitment and Selection

Diploma and degree programmes in midwifery have resulted in some institutions increasing their academic entry criteria. This could be an initial reaction to the high numbers of students failing courses (13% in the 1991/92 cohort). These failure rates have now fallen to 2.5% nationally (Table 4.2) possibly because institutions have become more experienced in designing and implementing three year programmes and selecting students. Personal qualities were considered to play a particularly vital role in determining competence for midwifery practice (Chapter 3) and there was evidence that some student problems could be attributed to personality difficulties (Chapter 5). An increasing cause of attrition seems to be students themselves choosing to leave the programmes (15% nationally in 1992/93). Case study institutions also referred to students having difficulties coping with the demands of the programme alongside their family commitments (Chapter 4) as the most common cause of attrition.

It is recommended therefore that:

1.1 Institutions pay particular attention to personal qualities (eg personal confidence, communication skills, attitudes) when selecting candidates (Chapters 5, 9)

1.2 Institutions give prospective students more insight during the admissions process into the reality of life as a student midwife of the challenges and experiences which student midwives, as opposed to other university students, are likely to encounter (Chapter 4)

2. Curriculum Design and Implementation

Curricula which adopt the ‘double wedge’ approach of theory first and practice

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later appear to reinforce the separation of theory and practice (Chapter 2). Students were found to have a comprehensive knowledge base and understanding of research but found difficulties "fitting in" in the clinical areas, achieving specific skills and meeting the requirements of the EC Midwives Directives (Chapter 7). Lack of dexterity in specific skills later on in the programme caused anxiety and hindered learning of more complex aspects of the holistic nature of midwifery (Chapters 5, 6, 7). Students who were not given the learning opportunity to 'be a midwife' before the end of the programme found the transition from student to midwife particularly difficult (Chapters 5, 11).

It is recommended therefore that when there is a review of the guidelines for midwifery programmes of education consideration is given to:

2.1 Emphasising the importance of programmes integrating theory and practice so that a theory first and practice later 'double wedge' type framework should be reconsidered (Chapter 2)

2.2 Stressing the need for the earlier use of theory in practice to enable students to develop the skills for problem framing and re-framing (Chapters 2, 11)

2.3 Encouraging institutions to enable students to learn specific skills earlier but in a structured learning context (Chapter 7)

2.4 Reconsidering the effectiveness of rigidly describing progression from simple to complex and learning about health before illness (Chapters 2, 11)

2.5 Including a period of consolidation at the end of the programme to provide students with the opportunity to 'be a midwife', develop management skills and gain confidence for the transition from student to registered midwife (Chapters 5, 8, 11)

3. Selection and Preparation of Assessors

There is evidence throughout Chapters 5 to 11 that effective selection and preparation of assessors is vital to ensure fair judgements are made about student capabilities in the practice setting. It takes time to fulfil the role of assessor and not all midwives want to be assessors. Those who opt out put additional burdens on their colleagues, unless workloads of assessors are adjusted to reflect their assessor responsibilities. Data support the need for institutions to monitor assessors' ability to teach and assess students and provide for initial and ongoing training of assessors (ENB Regulations, January 1995). ‘Borderline’ students are likely to be given a licence to practice if assessors are unable to fulfil their role because of poor preparation and support or staff shortages.

The following strategies are suggested:

3.1 Institutions provide sessions for the preparation and updating of assessors that are specific to meeting the requirements of pre-registration student midwives. These sessions might include the following:

- the roles of the teacher, student and assessor in assessment
- how to use the profiles and an overview of the curriculum
- appraisal of assessor's ability to assess
- counselling in assessment and problems of "failing students"
- promotion of the concept of mutual support in assessment
- responsibility to profession and public in assessment
- appropriate delegation of aspects of the midwife’s role to students
- information in sessions should be backed up with written guidelines eg a pocket sized booklet specifically for assessors
- regular updating sessions (especially to cover changes to assessment documents for students).

Contingency plans need to be in place if assessors cannot attend sessions provided in the education centre

3.2 Institutions set up or continue with support networks for assessors and midwife teachers

3.3 Institutions to have mechanisms in place to demonstrate their strategy for monitoring the quality of assessment in the practice setting.
(Midwife teachers and supervisors of midwives are likely to be the key people to verify practice assessments internally.)

3.4 Midwife teachers should be more proactive in relation to learning and assessment in the practice setting. (A partnership approach, as required by the ENB for Continuing Professional Education, 1991, is recommended - Figure 11.1.)

4. Good Practice in Assessment

In Chapter 3 the nature of competence was explored, including the ways in which competence can vary from context to context and over time. Assessment procedures did not provide much written evidence that students were assessed formally in relation to being able to assume responsibility and having the right personal qualities (Chapter 5). Gaps in assessment could potentially allow 'Borderline' students to qualify (Chapter 9) and inappropriate or over assessment could detract from more important areas of learning (Chapter 11). Many examples of good practice in assessment were identified but weaknesses were also found. Good procedures, dialogue and clear documents can help to make assessment more effective (Phillips et al 1994).

The following examples of good practice in assessment are recommended:

4.1 Core outcomes for programmes should be based on the statutory requirements and written in jargon[1]-free language. The model of competence (Figure 3.2) could provide an effective framework.

4.2 An assessment matrix should be developed to ensure a comprehensive assessment scheme and identify the most appropriate method of assessment for each element (Chapter 10)

4.3 Assessment schemes should be comprehensive. Ensuring the assessment of all three dimensions of the EME model of competence and their integration might be helpful

4.4 Assessment of the theory and practice of midwifery should be integrated

4.5 Evidence of achievement across a variety of contexts and over time should form the basis of summative assessment decisions

4.6 Assessment schemes should require sufficiency of evidence to demonstrate clearly whether a student has achieved or not achieved

4.7 Assessment requirements must be realistic and related to learning opportunities

4.8 Simulation should be a minimum acceptable assessment for those activities that are essential for contemporary midwifery practice but have not been experienced in a real situation

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[1] Jargon - "mode of speech full of unfamiliar terms" (Oxford Concise Dictionary 1964), used in this context to mean expressions for use within education as opposed to midwifery practice.

4.9 Written work is valued in helping students to deepen and broaden their knowledge and understanding of midwifery practice but overloading students with written work and using it as an inappropriate assessment tool can detract from essential learning in the practice environment

4.10 The use of portfolios, including the whole of the student's assessment profile, facilitates more effective learning and assessment because it:

- encourages the student to have a sense of ownership of their own progress and responsibility for their own professional development (UKCC Rule 33, 3c and ENB Creating Lifelong Learners, 1995)
- allows assessors to build up a picture of the student and form a baseline, for planning/assessing, which is especially important when several assessors involved
- reflects a philosophy of holistic assessment, ensuring the student is being assessed on aspects of the 'whole' role of the midwife

4.11 Documentation for assessment in practice settings should provide adequate sections to record discussions and feedback on progress from all midwives and midwife teachers involved in supervising and assessing the students

4.12 Each assessor should be provided with their own guidelines for facilitating and assessing student learning. These could include:

- outline of the roles of student, assessor and midwife teacher
- student's responsibility for their learning and achievement (this could reduce the assessor's personal feeling of responsibility if a student is not achieving)
- the importance of effective assessment, what to do if it seems likely the student will not achieve (remove taboo and feeling of assessor responsibility for student failure)
- the importance of documentary evidence

- the institution's format for effective assessment eg initial identification of learning needs and goals, minimum number of occasions for assessor to work with student, use of evidence from midwife colleagues, regular review of progress and constructive dialogue with student
- examples of how to complete the sections
- contact details for link midwife teacher/personal tutor/support systems

4.13 Midwife teacher should meet with the named assessor and student at least once during each assessment/allocation period - not just when problems arise

4.14 There needs to be regular evaluation and development, as necessary, of assessment procedures to include feedback from teachers, students and assessors. Reacting to one-off negative evaluations or complaints about assessment might not bring about programme improvements.

5. Using the Assessment Matrix

The EME team developed the matrix through involving representatives of all those who could be considered to be stakeholders in the process of producing competent midwife practitioners (Chapter 10). As the assessment matrix focuses on the competence required to fulfil the role of the midwife at the point of registration, it is applicable to both three year and shortened midwifery programmes.

It is recommended that it is made available to:

5.1 Approved midwife teachers to assist them in developing comprehensive and robust assessment strategies

5.2 Education Officers and specialist registry midwives to assist in the validation of pre-registration midwifery programmes

5.3 Assist supervisors of midwives when assessing the need of those returning to midwifery practice and for midwives who need to update their abilities to meet Changing Childbirth targets.

6. The Ideals of Midwifery Programmes and the Realities of Current Maternity Services

Midwives qualifying from the programmes have a strong commitment and enthusiasm for contemporary midwifery practice and a maternity service that is woman-centred (Chapter 5). However, there was evidence (Chapter 8) that pre-registration midwifery programmes do not always prepare students adequately for the reality of practice within the current maternity services. The programmes of education focus on community based care where students expect to carry a caseload and there is a needs meeting approach to maternity care. On qualification midwives are most likely to work in hospital situations where they are expected to have ward management skills and be able to participate in caring for women with complicated pregnancies and pre-existing medical problems. Although many received adequate support in their first posts, 42% (n = 16) felt they needed more support (Figure 8.1) and commented that units were very busy or short staffed.

Whilst it is important to ensure that students are prepared to meet the requirements of a rapidly evolving role, it is also important to prepare students for the realities of practice at present until the maternity services catch up with the ideals set out in Changing Childbirth (DoH 1993) and the pre-registration curriculum. Newly qualified midwives, regardless or whether three-year or shortened programme, need a short period of time to "settle in" to actually being a midwife. Labour ward was where most support was said to be needed.

It is recommended therefore that:

6.1 The effectiveness of curricula in relation to students developing management skills and involvement in caring for women with complications is monitored

6.2 Supervisors of midwives monitor the effectiveness of induction programmes for new midwives and the level of support given to them, especially those who are 'agency' or 'bank' midwives or who are lacking in confidence for their role.

CRITERIA FOR SELECTION OF THE SIX CASE STUDY INSTITUTIONS

A central part of the research plan for this project is the selection of six case study institutions from the colleges teaching three-year pre-registration midwifery diploma or degree programmes. Inevitably there are likely to be constraints affecting the final selection of case study institutions. In the main these will probably be:

- institution non-compliance because of involvement with other research projects, eg MRA, ACE, TYDE

- feasibility of access for our research team.

Whilst it would be helpful to give consideration to the organisational arrangements and curricula differences between institutions, the latter can only be achieved in part as not every institution is prepared to allow the research team access to its curriculum and it is not feasible to visit all institutions offering the programme. However, there will be many similarities between curricula in order for students to achieve the outcomes of the professional body (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) and the requirements of the European Community. In addition it has been identified, by a sample of institutions already visited, that curricula have developed quite significantly from that submitted for conjoint validation.

The organisational arrangements for midwifery education institutions are currently in a state of change and therefore this will not significantly influence the choice of the six sites as organisational arrangements might be very different in six to twelve months' time. However, where possible, known significant differences in organisational arrangements will be taken into consideration.

The following criteria will be used for making the selection, subject to further guidance from the Steering Group.

1 Course Completion Date

The timetable for the project requires us to select institutions that have cohorts that complete between April and December 1994.

2 Post-Registration Programmes

In order to gain some sort of comparison between pre-and post-registration route qualifiers, the majority of institutions selected should offer both programmes at diploma level.

3 Degree Programme

The remit of the project is to look at three-year pre-registration programmes. Very few three-year degree programmes are offered, but if possible it would be good to include one in the sample.

4 First and Second Cohorts

Only a minority of institutions offered the programme in 1990, but it is hoped that there might be a balance between institutions with a first and those with a second cohort of qualifiers.

5 Geography

Whilst some geographical spread is desirable, pragmatically it should not be overly constraining. There should however be a balance between urban and rural locations.

6 Size of the Institution/Midwifery Education Department

In view of the changes taking place in terms of location of midwifery education, it might be more appropriate to consider the number of health authorities/units/trusts used for practice placements and the organisation of those midwifery services.

7 Curricula

Significant variations in terms of course philosophy/framework/ assessment strategies should be important factors in the selection.

8 Pragmatic Considerations

Accessibility to the sites will be an important aspect and it might not be possible to select sites with course completion dates which are almost identical.

Ethical guidelines for the project are currently being developed, and these will form the basis for negotiation with the case study institutions. They will for example include an assurance that individual institutions will not be named in any research reports, unless this is unavoidable, and in that situation it will only happen after their approval has been sought.

DATA HANDLING AND ANALYSIS STRATEGIES

Before the data collection phase of the project, considerable thought was given as to:

- Fulfilling the research brief and addressing all the research questions
- Accessing the data
- Ensuring cooperation with participants on a longitudinal basis
- Recording and storage of the data to ensure accuracy, confidentiality and easy retrieval for analysis
- Managing the data during analysis
- Presentation of findings.

Ethical guidelines (Appendix 3) were drawn up to clarify what participants should expect from the project team and also to reassure them of anonymity and confidentiality. Participants were met by the project team and invited to participate, and after discussion on what participation would involve, they were assured that they were under no pressure to take part and that their teachers would not be informed if they did not want to be involved. In this way, the team felt participants would be more likely to stay with the project.

Data was collected from each case study site in a variety of forms and included examination of curriculum and course documents, student and assessment records, observation at assessor preparation workshops, boards of examiners and course evaluations, examination of assessment profiles, course work and evaluation reports and one-to-one and focus group interviews with participants as students and newly qualified midwives, their assessors and teachers; and with supervisors of midwives and midwives working with participants.

Data was stored in a locked office, to which only project team members had access and the identity of individuals and institutions involved was not disclosed to anyone outside the project team.

Following the initial analysis of curriculum documents, interviews provided the bulk of data and other sources were drawn on from time to time to inform or clarify issues arising. Interviews were semi-structured to ensure that all the questions were addressed and that the valuable time made available to researchers was not squandered. Interviews were tape recorded and transcribed in ASCII format to enable files to be analysed. Given the quantity of interview data collected, a computer programme (TEXTBASE ALPHA) was necessary to ensure that the data was manageable, enabling data to be coded, stored and retrieved more easily than manually.

Initially, interview transcripts were sifted through by the research team to allow main themes to emerge. These themes, once agreed, were then re-applied to interview files as codes. Next, coded segments relating to each theme were retrieved and analysed a second time, to explore issues in more depth.

Analysis was carried out site by site so that comparisons could be made. Later, findings were merged to give an overall perspective of pre-registration midwifery education across England. In this way the qualitative data collected from key informants, including students, course tutors, course leaders, Approved Midwife Teachers and clinical assessors were used as a crucial element in the analysis process for the evaluation. These data were used both to develop understanding of the processes of learning and assessment, and as a basis for developing a model of competence and an assessment matrix. The multiple perspectives provided by the data allowed triangulation of evidence to occur, and on this basis the validity of the evaluation was enhanced. Further validity tests were introduced through reporting back our emerging models to individuals within the case study institutions with an invitation for them to provide further feedback where this seemed appropriate.

An Outcome Evaluation of Pre-Registration Midwifery Programmes of Education: An ENB Commissioned Project

ETHICAL GUIDELINES

1.0 Introduction

These guidelines are intended to clarify the role of the evaluation and spell out the procedures that the evaluation team will adopt to protect individuals and institutions participating in the project. The guidelines are presented as answers to questions that participants might wish to ask.

2.0 What is the purpose of the evaluation project?

2.1 The overall purpose of the project is to evaluate the effectiveness of the pre-registration programmes of midwifery education in terms of their outcomes.

2.2 Phase 1 of the project will evaluate the immediate effectiveness of the pre-registration programmes of education in terms of outcome assessments. This will involve a sequence of developmental stages within the early months of the project, including a curriculum review, evaluation of existing assessment approaches and the development, if necessary, of new assessment tools.

2.3 Phase 2 will look at midwives one year after the completion of their pre-registration programme, and include an assessment of their knowledge, attitudes, competencies and skills as midwives and a study of their retention rates, career patterns and career intentions.

3.0 Who are the evaluation team?

Project Directors: Mrs Diane Fraser, Assistant Principal (Midwifery), Mid Trent College of Nursing & Midwifery
Professor Roger Murphy, School of Education, University of Nottingham
Research Midwife: Mrs Michelle Worth-Butler
Project Secretary: Mrs Chris Bexton.

4.0 How will the evaluators seek access to information?

4.1 The team is aware of the importance to be placed on the process of negotiating access to records and personal information whilst guaranteeing individual confidentiality.

4.2 Access in the first instance will be negotiated through the Approved Midwife Teacher in each institution offering three-year midwifery programmes.

4.3 In addition, the evaluation team would enter into negotiations with all participants in relation to access to information, anonymisation of observational and interview data in respect of all reports that are produced.

4.4 Arrangements for in-depth field work will be made in advance with the individuals concerned and will seek to be as unobtrusive as possible.

5.0 How will the data be stored?

5.1 Where feasible, data will be entered into microcomputers for database and textual analysis.

5.2 All detailed project data will only be open to access by team members.

5.3 Data of a personal nature shall not be kept longer than is necessary for the purpose of the study.

6.0 How will the information be reported?

6.1 Evaluation reports will contain three elements: description, interpretation and judgement. Criteria for judgement will be made explicit.

6.2 Case study institutions and individuals will not be named, and will be given pseudonyms or other anonymised description, where necessary, in the project reports, eg student, midwife.

EC MIDWIVES DIRECTIVES (EC 1980) (80/155/EEC)
concerning the taking up and pursuit of the activities of a midwife

Article 4

Member States shall ensure that midwives are at least entitled to take up and pursue the following activities:

1. to provide sound family planning information and advice;
2. to diagnose pregnancies and monitor normal pregnancies; to carry out the examinations necessary for the monitoring of the development of normal pregnancies;
3. to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
4. to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition;
5. to care for and assist the mother during labour and to monitor the condition of the foetus in utero by the appropriate clinical and technical means;
6. to conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery;
7. to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by manual examination of the uterus;
8. to examine and care for the new-born infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation;
9. to care for and monitor the progress of the mother in the post-natal period

and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant;

10. to carry out the treatment prescribed by a doctor;

11. to maintain all necessary records.

EC MIDWIVES DIRECTIVES (EC 1989) (89/594/EEC)
Practical and clinical aspects of midwifery programmes

Article 27

Advising of pregnant women, involving at least 100 prenatal examinations.

Supervision and care of at least 40 women in labour.

The student should also personally carry out at least 40 deliveries.

Active participation with breech deliveries. Where this is not possible because of lack of breech deliveries, practice may be in a simulated situation.

Performance of episiotomy and initiation into suturing. Initiation shall include theoretical instruction and clinical practice. The practice of suturing includes suturing of the wound following an episiotomy and a simple perineal laceration. This may be in a simulated situation if absolutely necessary.

Supervision and care of 40 women at risk in pregnancy, or labour or postnatal period.

Supervision and care (including examination) of at least 100 postnatal women and healthy newborn infants.

Observation and care of the newborn requiring special care including those born preterm, post term, underweight or ill.

Care of women with pathological conditions in the fields of gynaecology and obstetrics.

Initiation into care in the field of medicine and surgery. Initiation shall include theoretical instruction and clinical practice.

EME CONFERENCE

Effectiveness of Midwifery Education : Evaluation Project

ASSESSING COMPETENCE IN MIDWIFERY

16 MAY 1995

PROGRAMME

9.30	Registration and Coffee
10.00	**Opening of Conference**
10.15	**What are we trying to assess in Professional Education?** *Professor Michael Eraut* University of Sussex
10.45	Questions
10.55	Coffee
11.15	**Assessment in the workplace - the National Scene** *Sue Otter*
11.45	Questions
11.55	**Assessing Competence in Midwifery** *Diane Fraser, Roger Murphy* *Michelle Worth-Butler*
12.25	**Introduction to Discussion Groups**
13.00	**Lunch and Exhibition**
14.00	**Discussion Groups**
	Group 1 Group 2 Group 3
15.05	**Plenary Session**
16.00	**Close of Conference and Tea**

Effectiveness of Midwifery Education Evaluation Project: A Discussion Paper

Framework for the Research

The EME project is a three-year project, commissioned by the ENB, with a brief involving the evaluation of the outcome of three-year pre-registration midwifery programmes of education. The project is structured in two phases and phase one focuses on the competences of student midwives at the point of registration and the assessment of those competences. Addressing this issue systematically involved four main questions, which are outlined in the following section.

Phase One - Assessing the Competence of Pre-Registration Student Midwives

(1) What is competence in midwifery?
This entailed an examination of UKCC rules for outcomes of midwifery education; a review of literature on competence in midwifery, nursing, medicine, education and industry (Worth-Butler et al 1994, Worth-Butler et al 1995); an exploration of the views of midwives, parents, teachers and students; an analysis of midwifery curricula and assessment strategies; and an investigation of failure on pre-registration programmes.

(2) How can this 'competence' be assessed effectively?
Various approaches to assessing competence have been explored through an ongoing literature review, networking and attendance at conferences. Based on the feedback from number (1) above, a questionnaire was produced with a list of items for assessment, which was then circulated to members of the ENB's Professional Midwifery Advisory Network to explore their views on how these items could be assessed most effectively.

(3) How effectively is competence currently assessed in midwifery?
Curriculum documents have been analysed to examine the philosophies of institutions providing pre-registration midwifery education and the proposed outcomes of their courses. In addition, assessment strategies have been examined to see how they reflect the objectives outlined in the curriculum documents. Interviews with students, their mentors and teachers explored their views on the effectiveness and validity of the assessment strategy and their experiences of it.

The team intends now to use this data to produce some guidelines concerning good practice in assessment in midwifery education.

(4) How confident and competent to practise midwifery are students at the point of registration?
This involves an examination of decisions made by institutions regarding the competence of students at the point of registration. It also involves the examination of students' records and assessment profiles and interviews with students, their mentors and teachers. Reasons forthe failure of students in assessments are also being explored.

Phase Two - Newly Qualified Midwives in Practice

In phase two, students are followed up in their first year of practice as midwives. They will be interviewed to evaluate their continuing educational needs in relation to training opportunities available to them and their continued development as midwives in terms of competence and confidence. Interviews will also be carried out with midwives, managers and supervisors of midwives who work with them. In addition, retention rates, career patterns and career intentions of these midwives will be explored and the patterns within this group will be compared where possible with larger scale records of midwife retention and career patterns.

Phase two will also involve further development of the guidelines for good practice in assessment.

Although the conference has been organised to consider issues surrounding competence in midwifery, the key concerns should be relevant to similar debates among other professional groups such as doctors, nurses and teachers. These concerns that we hope will be a particular focus for discussion at the workshops are as follows:

- To what extent is it possible and/or desirable to define the qualities required of midwives at the end of their three-year education and training programme in terms of specific competences?
- At the moment there is no definitive list of competences required of midwives at the end of midwifery training programmes. Does this matter? Is it possible to monitor and accredit national standards for midwifery education without such a list?
- Different colleges have different assessment procedures. It is possible to define good practice in the assessment of midwifery education? If so, how should this be done, and what implications would this have for the national accreditation of midwifery education?
- Given the current demands made upon midwives employed in NHS Trusts, how can practitioners best be enabled to make valid, reliable and fair assessments of student competence to practise independently?
- Failure in professional education and training often poses all sorts of difficulties for teachers, assessors, colleges and students. How adequately is this being dealt with in midwifery education?
- Now that there is a requirement for student midwives to achieve academic credits at diploma/degree level, does the assessment of written work outweigh the assessment of students in the practice setting? If this is the case, how much can excellence in written work be taken to imply competence in midwifery practice?

Our own aim in wishing to promote a discussion of these questions, at this stage of our project, is to inform the planning of future work. The project still has eighteen months in which to undertake further data collection and analysis. We want to make the very best use of that time and will be grateful for any new insights and ideas that can be developed through this working conference. We also hope that participants will themselves get a great detail out of considering these challenging issues and questions.

Further details of our project will be presented at the conference, and a fuller interim project report is available on request from: the Project Secretary, EME Project, Midwifery Education Department, 'B' Floor, East Block, Queen's Medical Centre, Nottingham NG7 2UH.

CAREER PATTERNS OF CASE STUDY MIDWIVES IN THE FIRST YEAR FOLLOWING REGISTRATION

CAREER PATTERNS IN THE FIRST YEAR FOLLOWING REGISTRATION

Immediately following registration

#	full/part time		perm/ temp		Area of work						
	F/T	P/T	P	T	H	GP	IT	BA	AG	UE	NM
1	•		•				•				
2	•		•		•						
3	•		•								•
4	•		•		•						
5	•		•		•						
6	•	$	•		•						
7	•		•		•						
8	•		•		•						
9	•		•		•						
10		•		•	•						
11		•		•	•						gynae
12		•		•	•						
13									•		
14	•			•	•						

Six months following registration

#	full/part time		perm/ temp		Area of work						
	F/T	P/T	P	T	H	GP	IT	BA	AG	UE	NM
1	•		•				•				
2	•		•		•						
3	•		•								•
4	•		•		•						nnu
5	•		•		•						
6		•	•		•						
7	•		•		•						
8	•		•		• A						
9	•		•		•						
10		•		•	•						
11		&•		•	•						
12	•		•		•						
13			A	$					•		
14	•		A	•	•						

At end of first year

#	full/part time		perm/ temp		Area of work						
	F/T	P/T	P	T	H	GP	IT	BA	AG	UE	NM
1	•R		•				•				
2	•		•		•						
3	•		•								•B
4	•		•		•						nnu
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HEADINGS:

F/T	Full-time
P/T	Part-time
P	Permanent
T	Temporary
H	Hospital
GP	GP unit
IT	Integrated team
BA	Bank
AG	Agency
UE	Unemployed
NM	Non-midwifery

KEY:

•	Situation at beginning of each period
j/s	Job share
R	Thinking of reducing hours
&	Hours increased but still part-time
NNU	Neonatal unit
AG	Agency
UE	Unemployed
NM	Non-midwifery
$	Situation changed during period
A	Applied for another position
B	Hoping to do some bank workalso
GA	Going abroad
Gynae	Gynaecology ward
N/U	New unit

BEST COPY AVAILABLE

Immediately following registration												
#	full/part time		perm/ temp		Area of work							
	F/T	P/T	P	T	H	GP	IT	BA	AG	UE	NM
15		$		$	n/u$			•			
16	•		$	•	•						
17	•		•		•						
18	•			•	•						
19	•		•		•						
20	$			$	$					•	
21	•		•		n/u						
22	&	•	$	•	•						
23	•		$	•	•						
24	•		$	•	n/u						nnu
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28									•		

Six months following registration												
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At end of first year												
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Immediately following registration											
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	F/T	P/T	P	T	H	GP	IT	BA	AG	UE	NM
29	•			•	•						
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31	•			•	n/u						
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33	•			•	•						
34	•		•			n/u					
35		•	•		•						
36		•		•	•						gynae
37		•	•		•						
38	•		$	•	n/u						
39	•		•		n/u						

Six months following registration											
#	full/part time		perm/ temp		Area of work						
	F/T	P/T	P	T	H	GP	IT	BA	AG	UE	NM
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At end of first year											
#	full/part time		perm/ temp		Area of work						
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39	•		•		•						

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N/U	New unit

BEST COPY AVAILABLE

ELICITING THE VIEWS OF EXPERIENCED MIDWIVES ABOUT THE ASSESSMENT OF COMPETENCE IN MIDWIFERY

This paper sets out to summarise a process used by the EME team to explore the views of midwifery experts, - the ENB's Professional Midwifery Advisory Network (PMAN) on competence in midwifery. Some important issues were raised also in the course of this work, which not only concerned competence in midwifery, but also the appropriateness of the use of questionnaires in such work.

The professional and educational needs for effective assessment of competence include the need to ensure that assessment strategies are comparable across all institutions with responsibility for ratifying student eligibility for entry onto the professional register. With these issues in mind, the team set out to explore the notion of competence and the ways in which this competence could be assessed. Following an analysis of curriculum documents and exploratory work with practitioners and parents, a list of items was produced for assessment of the role of the midwife. This list of items then formed the basis of our work with the PMAN group of experts. Having considered the options available, the team opted for a two stage approach using a combination of methods. In stage one, PMAN members were sent questionnaires and in stage two, using group work the team explored the responses in more detail. This dual approach was chosen as team members were concerned about the limitations of using questionnaires alone.

There was a good response rate to the questionnaire stage and a preliminary analysis was carried out to show general trends. In the group work stage, a summary of these findings was fed back to the group who were very forthcoming with their views to the team. The group expressed concerns on the validity of findings, especially for use in policy decisions, as some felt that what they had filled in did not reflect their views on assessment or reflected what they themselves did rather than the most effective way to assess. Difficulties were highlighted in completion of the questionnaire. This would not have been evident had a two stage approach not been used. These difficulties related to the educational language used in the questionnaire, and difficulty making decisions about the most effective way to assess, especially for those who had little contact with students.

Some respondents were concerned about the atomised nature of the questionnaire which they felt was not consistent with a holistic philosophy of care. On the other hand, some respondents felt the some of the statements in the questionnaire were not specific enough for assessment. Some general issues were raised such as:

- the importance of effective assessor preparation and support
- sufficiency of evidence for making decisions about student ability
- items which should not be expected of students at the point of registration
- the need for summative assessment of communication and personal and professional skills
- the difficulty assessing communication and personal and professional skills
- the value of formative assessment to support and complement summative assessment
- the value of written work and simulation for the assessment of items which students are unlikely to have experience of before qualification
- areas that are best assessed in the college/university setting
- areas that are best assessed in the practice setting

PMAN members were asked to discuss two specific questions in small groups and feed back their main points to the group as a whole. Firstly they were asked to comment on "*What was surprising about the findings*" and the following points were raised:

- that so many respondents opted for a "belt and braces" approach to assessment. This involved unnecessary duplication of assessment in the college setting and the practice setting and implied that teachers might not trust midwife assessors to make judgements about a student's ability
- the range of items to be assessed
- that so few respondents had opted for assessment through simulation, especially as so many items were taught through simulation
- that some items which they felt were very important were not ranked higher in terms of importance for summative assessment by respondents, for example, normal delivery.

Question 2 required the groups to discuss the implications of the findings. Three major issues were raised:

1 Differing perceptions of managers, clinicians and supervisors were highlighted in terms of the emphasis they placed on items for assessment. Some members asked if there was a need for a national assessment framework in the light of the differences highlighted.

2 The danger of moving towards a task approach to assessment which neglects understanding and knowledge and care based on individualised needs. Members were concerned that without assessment strategies that made explicit the complex and holistic nature of midwifery care, and without an effective argument in favour of midwives providing holistic care, cheaper health care workers with NVQ qualifications could be assigned some of the activities of a midwife by managers.

3 The emphasis on assessment of theory could detract from the value of assessment in practice especially where assessments made in one setting

were repeated in the other. Many felt it was more appropriate to improve on the preparation of assessors and on the quality of practice assessment rather than a "belt and braces" approach. In addition, teachers had a role in ensuring reliability between assessors.

A discussion of the appropriateness of the methodology used in the light of the findings and in the light of current literature is also available in the article previously referred to. The decision to augment the questionnaire phase with group work proved to be invaluable in retrospect. On the basis of questionnaire analysis alone, it is likely that the data would not have accounted for the problems of interpretation that a considerable number of group members had experienced. In fact, it is probable that team members would not have been made aware of these problems and thus findings would have been interpreted inappropriately.

Nonetheless, the exercise produced a considerable amount of qualitative data on assessment and the main issues are summed up in the concluding sections. The paper concludes with the hope that some of the problems in constructing and interpreting questionnaires have been highlighted and those contemplating the use of questionnaires will consider their limitations before placing too much emphasis on them.

The complete article was published in *Midwifery* 12(4): pp 182 - 190

APPENDIX 8b

No:

EME Evaluation Project

Assessment strategies for pre-registration midwifery programmes of education

In this questionnaire you will find a list of items for assessment which we have generated through our examination of midwifery curricula and assessment documents and from work we have carried out with midwives, midwife teachers and parents. We would be very grateful if you could assist us to decide on the most effective way to assess these items.

INSTRUCTIONS FOR COMPLETION OF THE QUESTIONNAIRE

1) Place a letter in each of the columns according to whether you believe each item listed should be assessed :

- (S) Summatively*	(may also have involved formative assessment and student self-assessment)
- (F) Formatively **	(there is no need or it is not appropriate to assess this item summatively)
- (N) No need to assess	there is no need to assess this activity as a separate item
- (U) Unlikely	it is unlikely that students will have enough opportunities for their performance to be assessed
- (?) Unsure	

2) Codes for the column headings are as follows:

Pract = Assessment to take place in the practice setting e.g. hospitals, homes, clinics etc.

Simul = Assessment to take place in a workshop, classroom or other such simulated settings e.g. student demonstrating a breech delivery using models, acting out situations etc.

Theory = Assessment of written assignments, examinations, seminars, orals etc.

* *SUMMATIVE - Assessment to make judgements about a student's overall level of achievement. Results contribute to the final grade or to certification.*

** *FORMATIVE - Continued and systematic appraisal to determine a student's degree of mastery, to provide feedback and to identify learning needs.*

EXAMPLE :

Pract	Simul	Theory	Comments
			urine testing
			vaginal examination

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

Pract	Simul	Theory	CLINICAL SKILLS	Comments
			temperature, pulse	
			blood pressure	
			urine testing	
			abdominal examination	
			breast examination	
			use of pinard stethoscope	
			use of sonicaid	
			use of CTG monitoring	
			drug calculation, administration and recording	
			injection technique	
			checking emergency equipment	
			use of TENS	
			vaginal examination	
			ability to carry out normal deliveries - sitting	

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

Pract	Simul	Theory		Comments
			" - squatting	
			" - all fours	
			" - birthing chair	
			" - left lateral	
			" - in water	
			administering local anaesthetic	
			performing an episiotomy	
			siting an intravenous infusion	
			maintaining an intravenous infusion	
			suturing the perineum	
			management of the third stage of labour -controlled cord traction	
			" -physiological	
			pre-operative care	
			post-operative care	
			application of a fetal scalp electrode	
			catheterisation	
			venepuncture	

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

Pract	Simul	Theory	Comments
			assisting medical staff
			epidural top-up
			infection control
			cardio-pulmonary resuscitation
			aseptic technique
			assisting the anaesthetist
			assisting during a Caesarean Section
			resuscitation of the newborn
			assisting with breast feeding
			postnatal assessment
			examination of the newborn
			removal of sutures
			hygiene needs of the mother
			preparation of bottle feeds
			providing care for baby
			Guthrie test
			BM test
			induction of labour management

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

Pract	**Simul**	**Theory**		**Comments**
			caring for women who are ill	
			caring for the sick or small neonate	
			ability to recognise deviations from the norm	
			ability to respond appropriately to deviations from the norm	

COMMUNICATION SKILLS

			active listening	
			observation skills	
			information technology skills	
			ability to clarify and summarise	
			assertiveness skills	
			counselling skills	
			ability to communicate with different client groups	
			interpersonal skills	
			caring in loss or disability	
			report writing skills	
			verbal reporting skills	
			obtains necessary information	

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

TEACHING SKILLS

Pract	Simul	Theory		Comments
			to parents one to one	
			to parents in a group	
			assessing parents educational needs	
			health promotion	
			to other members of staff	

MANAGEMENT SKILLS

			ability to prioritise	
			time management	
			resource management	
			organisational skills	

KNOWLEDGE

			having an adequate knowledge base	
			ability to synthesise knowledge for effective decision making	
			integration of knowledge, skills and attitudes	
			integration of theory and practice	

PERSONAL AND PROFESSIONAL QUALITIES

			trustworthy	

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

Pract	Simul	Theory		Comments
			ethical	
			confident	
			caring, kind and gentle	
			non-judgemental	
			self awareness	
			demonstration of critical analysis	
			ability to empower women and involve them in their own care	
			ability to care holistically, using an appropriate model of care	
			ability to facilitate decision making	
			awareness of own limitations and when to seek advice or assistance	
			awareness of the responsibilities of a midwife	
			ability to make professional judgements	
			application of research to practice, where appropriate	
			ability to interpret research	
			accurate maintenance of records	
			critical evaluation of practice	
			application of equal opportunities policies to practice.	

COMMENTS

Please use this section to comment on any section of the questionnaire and on assessment in general. Your views would be very welcome, particularly on items not included. We would also welcome your comments on difficulties or ambiguities, which you were aware of while completing this questionnaire. Please write on the reverse of the sheet if necessary.

THE EME TEAM THANK YOU FOR YOU ASSISTANCE

An ENB commissioned research project

EXPLORING PARENTS' VIEWS

The ENB's Project Steering Group agreed with us that any model of competence which fails to draw adequately upon the consumers' views of midwives is likely to be inadequate. Although there is much published work in the field, many reports are limited to patient satisfaction surveys and from organisations such as the National Childbirth Trust (Bramadat and Driedger, 1993, Hutton, 1994).

There are a variety of ways in which parents' views can be collected and as part of this project we explored three different approaches. These were: a questionnaire, in-depth semi-structured interviews and diary recordings. Following this exploratory work (Fraser D, Murphy R and Worth-Butler M 1996) it was agreed with the Project Steering Group that a more in-depth study would help with the development of the assessment matrix but was outside the scope of the current project. Instead, one of the team agreed to commence such a study, as part of her own research project, and feed data into the project as it emerged. This project will be lodged with the ENB in due course.

The ENB 10 Key Characteristics

From Creating Lifelong Learners: partnerships for care
Guidelines for the Implementation of the UKCC's Standards
for Education and Practice Following Registration

English National Board for Nursing, Midwifery and Health Visiting
June 1995

1 Accountability

Expert practitioners should have the ability to exercise professional accountability and responsibility, reflected in the degree to which they use professional skills, knowledge and expertise in changing environments, across professional boundaries, and in unfamiliar situations.

2 Clinical Skills

Expert practitioners should have specialist skills, knowledge and expertise in the practice area where they are working, including a deeper and broader understanding of client/patient health care needs, within the context of changing health care provision.

3 Use of Research

Expert practitioners should have the ability to use research, enquiry and scholarship to plan, implement and evaluate concepts and strategies leading to improvements in care.

4 Team Work

Expert practitioners should have skills in team working, including multi-professional team working in which the leadership role changes in response to changing client needs and team leadership and team building skills to organise the delivery of care.

5 Innovation

Expert practitioners should have the ability to develop and use flexible and innovative approaches to practice that are appropriate to the needs of their client/patient or group, and are in line with the goals of the health service and the employing authority.

6 Health Promotion

Expert practitioners should understand and use health promotion and preventative policies and strategies to achieve service targets.

7 Staff Development

Expert practitioners should have the ability to facilitate and assess the professional and other development of staff for whom they are responsible, and to act as a role model of professional practice.

8 Resource Management

Expert practitioners should have the ability to take informed decisions about the allocation of resources for the benefit of individual clients and the client group with whom they are working.

9 Quality of Care

Expert practitioners should have the ability to evaluate the quality of care delivered as an ongoing and cumulative process.

10 Management of Change

Expert practitioners should have the ability to facilitate, initiate, manage and evaluate change in practice to improve the quality of care.

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TWENTY-FOUR

JULY 1997

An outcome evaluation of the effectiveness of pre-registration midwifery programmes of education

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Abstract

This three-year project evaluated the effectiveness of the outcomes of pre-registration midwifery education programmes. This was achieved through a two phase study. The first involved a review of existing three-year midwifery programmes and identification of a cohort of students for in-depth study. The second phase studied this same cohort of students, now midwives, into their first year in practice.

A survey of all institutions providing pre-registration midwifery programmes was carried out initially to undertake an analysis of curriculum intentions and to select six case study sites. The multi-method approach for this evaluation study was largely qualitative where case studies were carried out alongside a curricula analysis.

Main findings relate to: recruitment and selection, curriculum structure, appropriateness and robustness of assessment schemes, the preparation of and support for assessors, the role of the teacher in the assessment process and the ideals of midwifery programmes alongside the realities of current maternity services. Outcomes included the development of a model of competence, and an assessment matrix.

Methods

The first phase of the study involved an examination of the philosophy, theoretical framework, design and content of curricula as supplied by the Approved Midwife Teachers from twenty-three institutions offering the pre-registration programme at the time the project commenced in October 1993. A multi-site case study approach was used to collect data about programme design, teaching and assessment methods, perceptions and actions of participants and stakeholders. Alongside the case study work a multi-method approach was used to formulate a model of competence in midwifery and an assessment matrix. Data collection involved:

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- semi-structured interviews with the 39 case study students on two occasions in the final year of their programme, at six months and at one year after qualification;
- semi-structured interviews with each student's assessor, teacher, preceptor (or midwife colleague) and Supervisor of Midwives (or manager);
- observations of Board of Examiners meetings;
- observations of preparation of assessor workshops;
- scrutiny of programme and assessment documents relating to the whole cohort of students in each case study institution;
- literature review of professional competence (Worth-Butler et al 1994, 1995);
- a mid-project conference;
- postal questionnaires and follow-up group work with the ENB Professional Midwifery Advisory Network Members (Worth-Butler et al 1996);
- exploratory survey and group work with parents (Fraser et al 1996);
- focus groups in each of the case study institutions.

Main Findings

1. *Recruitment and Selection*

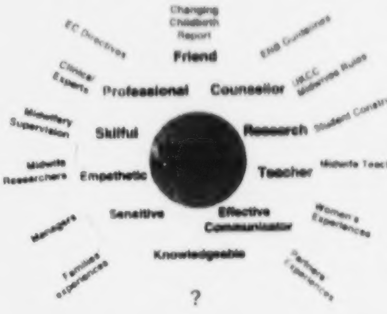
- Diploma and degree level programmes in midwifery have resulted in some institutions raising their academic entry criteria quite significantly. This could be an initial reaction to the high number of students failing courses. The failure rate was 13% in the case study institutions for the 1991/1992 cohort. This compares with a national failure rate of 6.7% in 1991/92 which fell to 2.5% in 1992/93.
- A common cause of attrition was students being unable to balance the demands of the programme alongside family commitments and expectations. Other explanations for attrition included: inexperience in selecting students for the new programme, students who found they had made a wrong choice, early failure in written work, failure towards the end in practice based assessment.
- Personal qualities appear to play a particularly vital role in determining competence for midwifery practice and should be considered alongside academic abilities.

2. *Curriculum design*

- Curricula were mostly designed with a majority of theory first and more practice later. This structure, added to a compartmentalised arrangement of subject disciplines, tended to cause a theory/practice split and potentially wasteful learning early on as described by Eraut et al (1995).
- All programmes demonstrated good evidence of a variety of teaching and assessment methods, a student-centred approach to learning and an emphasis on lifelong learning.
- Students had a very comprehensive knowledge base and understanding of research. Lack of practical skills gave them difficulty fitting-in in the clinical areas during early placements.
- Lack of dexterity in some important skills late on in the programme, caused students anxiety and hindered learning of more complex aspects of the holistic nature of midwifery.
- Students who were not given the learning opportunity to be a midwife before the end of the programme felt less well able to cope with the transition from student to midwife.

3. *The need for a model of competence*

- There was no commonly shared definition of a competent midwife at the point of registration.
- Different stakeholders valued or stressed different aspects of the role of the midwife (fig. 1).


Changing Childbirth Report
EC Directives
ENB Guidelines
Friend
Clinical Experts
Professional
Counsellor
UKCC Midwives Rules
Midwifery Supervision
Skilful
Research
Student Constructs
Midwife Researchers
Empathetic
Teacher
Midwife Teachers
Sensitive
Effective Communicator
Women's Experiences
Managers
Knowledgeable
Families experiences
Partners Experiences
?

- An acceptable model of competence needs to encompass the complexity and holistic nature of the role of the midwife and demonstrate capability across contexts and over time.
- A model was developed that incorporated three essential interlinked dimensions of competence. This model is flexible and

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has different emphases according to context. The three dimensions are described as (fig. 2):

- the ability to be autonomous and professional but 'with woman'

  (professional/friend approach)
- the ability to provide individualised care

  (individualised approach)
- a sound knowledge base and appropriate skills for the provision of midwifery care

  (clinical competence)

DIAGRAM OF A HOLISTIC, INTEGRATED MODEL OF A COMPETENT MIDWIFE

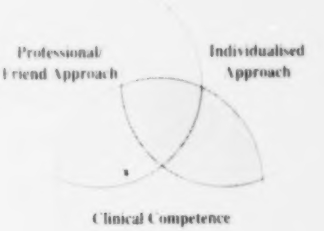

Fig. 2

4. *Preparation for practice*

- Study midwives were well prepared to provide holistic midwifery care for women during normal pregnancy and on a one-to-one basis. They had a comprehensive knowledge base, could use research in practice and had the skills to fulfil statutory requirements.
- The transition from student to midwife is difficult and was often accompanied by a drop in confidence. Confidence improved quickly if given good support.
- Variations existed between providing new midwives with good support and "throwing them in the deep end". Many were expected to manage busy short-staffed maternity wards soon after qualifying.
- Support for new midwives was needed most on delivery wards and when they were asked to care for women with complications. Students described as borderline appeared to have least support in their first post.
- Some skills had not been developed sufficiently for all new midwives to undertake them without supervision e.g. catheterisation, episiotomy, epidural top-up and drug administration. Most skill deficits were made up quickly following qualification.
- Midwives in their first year were found to be committed to the concept of woman-centred care and demonstrated enthusiasm for contemporary midwifery practice.
- By the end of the first year in practice most study midwives were described by managers and supervisors as competent, confident midwives who learned quickly, were able to identify their own learning needs, were questioning and reflective practitioners and keen to undertake further study.
- A few study midwives experienced disillusionment within a maternity service which prevented them from providing high quality, individualised woman-centred care.

5. *Assessment strategies*

- Examples of good practice in assessment included: written procedures and guidelines for assessors, clear assessment documents and space to record dialogue as recommended in the ACE report (Phillips et al 1994).
- Assessment schemes tended to neglect or under-assess aspects such as: personal qualities and attitudes, predictive capability to assume responsibility and accountability as a midwife, management skills, care of women who are ill or have special needs, the administration of drugs.
- Institutions experienced difficulties reconciling university and ENB assessment requirements. Substantial written assessment demands detracted from practice based assessment.
- Assessments were most effective where there was integration of theory and practice and an appropriate context for assessment.
- Assessors found it difficult to fail students especially when colleagues had given a pass grade previously and when it was near the end of the programme.
- Assessors were not always adequately prepared to teach and assess students particularly in relation to: expectations of the new programme, how to fill in the assessment profile, developing student problem-solving skills, giving students more responsibility towards the end of the programme, failing students.
- Assessment decisions in practice were more effective when there was good

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communication between student, assessor and teacher.

- Institutions did not use a framework for developing or judging the robustness of assessment schemes. The production of an assessment matrix for use nationally was welcomed (fig. 3).

Conclusion

The overall finding of the project is that the three-year pre-registration route into midwifery is an effective preparation for contemporary midwifery practice. In spite of initial prejudices held by some experienced midwife practitioners and teachers, the commitment and enthusiasm of the case study students towards woman-centred midwifery practice has done much to change their views. Many of these midwives had been impressed by students' knowledge and understanding of the theory underpinning midwifery practice, their reflective questioning attitudes, wide reading and use of research.

Fig. 3 **EXTRACT FROM THE ASSESSMENT MATRIX**

Cross-references	**COMPETENCE DIMENSION: Professional/Friend**				
	Area of competence expected at point of registration.	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education environment	Simulation
CC	1) Has a friendly, caring approach to women and can make them feel comfortable in any context.	1.1 personal qualities	Essential	Possible	Possible
		1.2 attitudes	Essential	Possible	Possible
(vi) (viii)	2) Communicates with women and their partners, as a professional &/or friend according to context.	2.1 supportive/reassuring	Essential		Possible
		2.2 giving advice/guidance	Essential		Possible
		2.3 involves other team members	Essential	Possible	
		2.4 use of records	Essential		
CC Code (13) (vii)	3) Respects the woman's right to choose/empowers women to be in control and involved in their care.	3.1 uses literature & research	Possible	Possible	
		3.2 explores woman's preferences	Essential		
		3.3 explains protocols	Possible	Possible	
		3.4 seeks permission from woman before acting	Essential		
EC (ix) Code (42) (vii)	4) Understands and practices within the legislation governing midwifery practice, including keeping thorough and contemporaneous records.	4.1 keeps accurate and detailed records	Essential	Possible	
		4.2 knowledge and understanding of Midwives Rules and other relevant legislation	Possible	Possible	
		4.3 knowledge and understanding of local requirements arising from legislation	Possible	Possible	

Details about the project

The three-year project was a collaborative venture between the Division of Midwifery and the School of Education in the University of Nottingham. The EME (Effectiveness of Midwifery Education) project was commissioned by the English National Board for Nursing, Midwifery and Health Visiting and commenced in October 1993. The two phase study investigated effectiveness at the end of the programme and in the light of one year's midwifery practice.

The report will be of particular interest to institutions offering pre-registration midwifery. The assessment matrix should be of interest to Supervisors of Midwives for use as the basis for assessing the needs of those returning to midwifery practice. It should also be of interest to the profession as midwifery seeks to respond to the challenges set out in Changing Childbirth (DoH 1993).

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